

5582

## CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Cullen</b>		LENGTH OF STAY (in this place) <b>9 days</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <b>Baltimore City</b>		<b>3Y01-4</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Victor Cullen State Hosp.</b>				STREET ADDRESS (If rural give location) <b>1119 Proctor Street</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>Clarence Howard Barnes</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>6 3 19 55</b>			
5. SEX: <b>M</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH: <b>6/22/1900</b>	9. AGE last birthday <b>54</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Home Improvements, Carpentry</b>				10B. KIND OF BUSINESS OR INDUSTRY: <b>Maryland.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <b>George E. Barnes</b>				14. MOTHER'S MAIDEN NAME: <b>Margaret Adler</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W.I 214-01-9217</b>		17. INFORMANT & ADDRESS: <b>Clarence Howard Barnes 1119 Proctor St., Balto.-2- Md.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Pulmonary tuberculosis</b>						<b>2 yrs.</b>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<b>Arteriosclerotic heart disease</b>	
19A. DATE OF OPERATION: <b>0</b>						19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>5/25/19 55</b> to <b>6/3/19 55</b> that I last saw the deceased alive on <b>6/3/19 55</b> , and that death occurred at <b>9 A. M.</b> from the causes and on the date stated above.							
SIGNATURE <b>Edward P. Ritchings</b>		M. D. <b>Victor Cullen State Hosp. Cullen, Maryland.</b>		DATE SIGNED <b>6/3/55</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>6/18/55</b>		NAME OF CEMETERY OR CREMATORY <b>Baltimore Cem.</b>		LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>6/3/55</b>		REGISTERED SIGNATURE <b>I.B. Lyon</b>		24. FUNERAL DIRECTOR <b>Wm. J. Tickner</b>		ADDRESS <b>Balto., Md.</b>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JUN 6 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05566

5593

## CERTIFICATE OF DEATH

Reg. Dist. No. 131.....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u> MARYLAND		STATE <u>Md.</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Frederick</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Frederick</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural give location) <u>1</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Annie R. Baugher</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>June 14 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>2-2-1883</u>
9. AGE last birthday: <u>72</u> yrs.		IF UNDER 1 YEAR: Months Days	IF UNDER 24 Hrs.: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>own home</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Lawson P. Summers</u>		14. MOTHER'S MAIDEN NAME: <u>Julia M. Fredericks</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service): <u>no</u>		16. SOCIAL SECURITY NO.: <u>none</u>	
17. INFORMANT & ADDRESS: <u>Roy Baugher, Frederick, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>			<u>1/2 hr</u>
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May 3, 1955</u> , to <u>June 14, 1955</u> , that I last saw the deceased alive on <u>June 10, 1955</u> , and that death occurred at <u>5:10 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>J. Elmer Harp</u>		DATE SIGNED <u>6-14-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-16-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Ch. of Brethren Cem.</u>		LOCATION (City, town, or county) (State) <u>Frederick Co. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>16 June 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>	
24. FUNERAL DIRECTOR <u>Bladhill Co.</u>		ADDRESS <u>Middletown, Md.</u>	

BUREAU V. S.

JUN 20 1955

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 13

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Frederick	MARYLAND	STATE Maryland	COUNTY Frederick
CITY (If outside corporate limits, write RURAL and give nearest town) 11 Frederick	LENGTH OF STAY (in this place) 28 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) 11 Frederick	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 5 West All Saints Street		STREET ADDRESS (If rural give location) 1 5 West All Saints Street	
3. NAME OF DECEASED: (First) (Middle) (Last) James Clinton Bell		4. DATE OF DEATH: (Month) (Day) (Year) June 15 1955	
5. SEX: Male	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed	8. DATE OF BIRTH: May 4, 1879
9. AGE last birthday: 76 yrs.		10. DATE OF BIRTH: 11/6 75 yrs.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Hotel Laborer		10b. KIND OF BUSINESS OR INDUSTRY: [blank]	
11. BIRTHPLACE (State or foreign country): Maryland, Frederick, Co		12. CITIZEN OF WHAT COUNTRY? U.S. of Am	
13. FATHER'S NAME: Nathan E. Bell		14. MOTHER'S MAIDEN NAME: Agnes Price	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) 9		16. SOCIAL SECURITY No.: 214-10-2257	
17. INFORMANT & ADDRESS: Noble Stanton, 5 West All Saints St Frederick Md.			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
442x Immediate cause		6 mo	
(a) Ch. Cardio Renal Vascular Disease			
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.		10 yrs	
(b) Arterio Sclerosis			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: 0		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1-2 1955, to 6-15 1955, that I last saw the deceased alive on 6-15 1955, and that death occurred at 5:15 PM, from the causes and on the date stated above.			
SIGNATURE (Degree or title) C.E. Hicks M.D.		ADDRESS DATE SIGNED 7 E. Hicks M.D. 6-17-55	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF June 18	
NAME OF CEMETERY OR CREMATORY St. Paul, Della, Md		LOCATION (City, town, or county) (State) Della, Fred Co. Md	
DATE REC'D BY LOCAL REGISTRAR 17 June 1953		REGISTRAR'S SIGNATURE Elizabeth S. Heck	
24. FUNERAL DIRECTOR C.E. Hicks, 111		ADDRESS 24 West saints St Fred. Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 20 1955

BUREAU V. S.

## CERTIFICATE OF DEATH

Reg. Dist. No. 138

## 1. PLACE OF DEATH:

COUNTY **Frederick** MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) **Monrovia** LENGTH OF STAY (in this place) **33 yrs.**  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Maryland** COUNTY **Frederick**  
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN **Monrovia**  
 STREET ADDRESS (If rural give location)

## 3. NAME OF DECEASED:

(First) (Middle) (Last)  
**Wm. Bertha Betson**  
 4. DATE OF DEATH: **June 24** 19**55**  
 5. SEX: **female** 6. COLOR OR RACE: **white** 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) **married** 8. DATE OF BIRTH: **4-26-1894** 9. AGE last birthday: **61** yrs. Months Days Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired **housewife** 10b. KIND OF BUSINESS OR INDUSTRY: **home** 11. BIRTHPLACE (State or foreign country): **Maryland** 12. CITIZEN OF WHAT COUNTRY? **U.S.**

## 13. FATHER'S NAME:

**James W. Brashears**

## 14. MOTHER'S MAIDEN NAME:

**Betty Brunner**

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) **no** (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: **none**

## 17. INFORMANT &amp; ADDRESS:

**Harry C. Betson, Monrovia, Md.**

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

**162X**  
 Immediate cause

(a) **Carcinoma of Lung (Bronchogenic)**  
 DUE TO

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

Interval Between Onset And Death

**1 year**

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

**Atherosclerotic Heart Disease****2 years**

## 19a. DATE OF OPERATION:

**None**

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY ?

Yes ☒ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from **July 1, 1954**, to **June 24, 1955**, that I last saw the deceased alive on **June 13, 1955**, and that death occurred at **5 AM**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL (Specify)

**BURIAL**

## DATE THEREOF

**6-27-1955**

## NAME OF CEMETERY OR CREMATORY

**Pine Grove**

## LOCATION (City, town, or county)

**Mt. Airy, Maryland**

(State)

DATE REC'D BY LOCAL REGISTRAR

**June 26-55**

## REGISTRAR'S SIGNATURE

**Lucian K. Falconer**

## 24. FUNERAL DIRECTOR

ADDRESS

**C. M. Waltz, Winfield, Maryland**

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 19 1955

RECEIVED



05568

## MARYLAND STATE DEPARTMENT OF HEALTH

5584

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <b>FREDERICK</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>MARYLAND</b> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>NR. FREDERICK</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>723 E. BELVEDERE AVENUE</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>EN ROUTE HOSPITAL IN AMBULANCE</b>		STREET ADDRESS (If rural, give location) <b>BALTIMORE 3401.4</b>	
3. NAME OF DECEASED (First) <b>NORMAN</b> (Middle) <b>EUGENE</b> (Last) <b>BROOKS</b>		4. DATE OF DEATH (Month) <b>JUNE</b> (Day) <b>27</b> (Year) <b>1955</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>AUG. 9, 1891</b>
9. AGE last birthday <b>63</b> yrs.		10. If under 1 year Months <b>6</b> Days <b>3</b> If under 24 hrs. Hours <b>1</b> Mins. <b>0</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>WHOLESALE DRUGS</b>	
12. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		13. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
14. FATHER'S NAME <b>THOMAS R. BROOKS</b>		15. MOTHER'S MAIDEN NAME <b>ISABELLE V. WILLS</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>25-10-4924</b>	
18. INFORMATION AND ADDRESS <b>Mrs. J. C. Burke 723 E. Belvedere Avenue</b>			

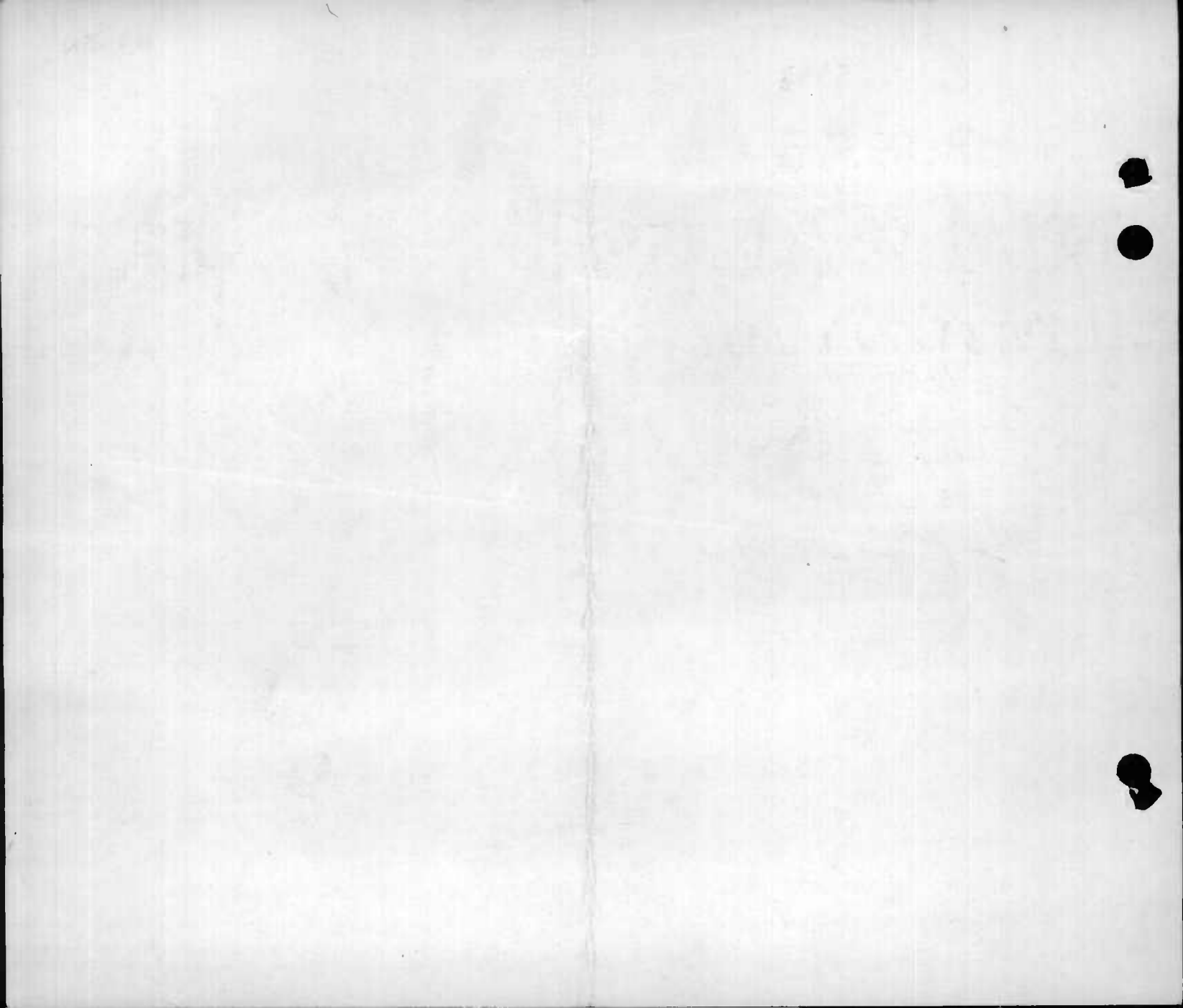
## 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.0 Immediate cause (a) <b>CORONARY ARTERY OCCLUSION</b>		<b>30 MINS</b>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) (b) <b>ARTERIO SCLEROTIC HEART DISEASE</b>		<b>YRS.</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <b>0</b>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <b>NONE</b>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <b>Robert J. Juine M.D.</b>		DATE SIGNED <b>Box 236, RRD 6, Frederick, Md. 6/27/55</b>	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF <b>July 1, 1955</b>	NAME OF CEMETERY OR CREMATORY <b>St. Mary's (Hampton)</b>	LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
DATE REC'D BY LOCAL REG. <b>6-29-55</b>	REGISTRAR'S SIGNATURE <b>H.W. Nelson</b>	24. FUNERAL DIRECTOR <b>Horace F. Burgee</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



05569

## MARYLAND STATE DEPARTMENT OF HEALTH

5581

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 141

1. PLACE OF DEATH COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Virginia</u> COUNTY <u>Loudon</u>	
35 CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brunswick</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lovettsville</u> 83X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>EDWARD</u> (Middle) <u>LEROY</u> (Last) <u>BROWN</u>		4. DATE OF DEATH (Month) <u>JUNE</u> (Day) <u>26</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>6-14-1931</u>
9. AGE last birthday <u>24</u> yrs.		If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sailor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Charles Clayton Brown</u>		14. MOTHER'S MAIDEN NAME <u>Mary Susan Green</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>Still in</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Mr. Mary Susan Brown, Lovettsville Va.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) <u>819X</u> Immediate cause <u>Compound Fracture of Skull;</u>			<u>Inst.</u>
(b) <u>Fracture Cervical Vertebra</u>			<u>Inst.</u>
(c) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> PLACE (Home, farm, factory, street, office bldg., etc.) <u>Highway</u> (CITY OR TOWN) <u>Brunswick</u> (COUNTY) <u>Frederick</u> (STATE) <u>Md.</u>			
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>June 26, 1955 4 p.m.</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR? <u>Auto he was driving struck bridge at high rate of speed</u>			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>Robert J. June, M.D., R7D#6, Frederick, Md.</u>		DATE SIGNED <u>6-26-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> DATE THEREOF <u>6-28-55</u> NAME OF CEMETERY OR CREMATORY <u>Union</u> LOCATION (City, town, or county) (State) <u>Lovettsville Va.</u>			
DATE REC'D BY LOCAL REG. <u>June 26-55</u> REGISTRAR'S SIGNATURE <u>Kathryn N. Brown</u>		24. FUNERAL DIRECTOR <u>C. H. Tate &amp; Beg Brunswick Md.</u> ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 1 1955

BUREAU V. S.

07724

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

Reg. Dist. No. 138

1. PLACE OF DEATH: COUNTY <u>Mt. Airey Rt #1, Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD</u> COUNTY <u>FREDERICK</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>NEAR NEW MARKET</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>NEAR NEW MARKET</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>CHARLES WILBUR CARSON</u>		4. DATE OF DEATH <u>JUNE 22</u> 19 <u>55</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>MAY 6-1896</u> 59 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>CHARLES CARSON</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH COUGHLIN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Mrs ELIZABETH FALCOWER NEW MARKET MD</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

976X

Immediate cause

(a) Gunshot wound of headInterval BETWEEN ONSET AND DEATH  
Immediate

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing in the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>None</u>	(CITY OR TOWN) <u>nr New Market</u> (COUNTY) <u>Frederick</u> (STATE) <u>Maryland</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>June 22 1955 7A m.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Nnt while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Self-inflicted gunshot wound</u>	

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☒ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Charles H. Conley, Jr. M.D. Acting Dep. Med. Exam.

Frederick, Maryland

6/22/55

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>BURIAL</u>	<u>JUNE 24-1955</u>	<u>MT OLIVET CEMETERY</u>	<u>FREDERICK</u>	<u>MD</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<u>June 23-55</u>	<u>Lucian K. Falconer</u>	<u>W. E. Falconer New Market MD</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 19 1955

BUREAU V. S.

5585

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Fred.	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Rural Frederick, Co.		LENGTH OF STAY (in this place) 30 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Frederick, Co.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Harmony Grove... Haywood Rd.				STREET ADDRESS (If rural give location) Harmony Grove.... Haywood Rd.			
3. NAME OF DECEASED: (First) Charles (Middle) Wilson (Last) Cartnail			4. DATE OF DEATH: June 7 19 55				
5. SEX: Male		6. COLOR OR RACE: Colored		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: Sept. 13, 1884	
				9. AGE last birthday: 70 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Farm Helper				10b. KIND OF BUSINESS OR INDUSTRY: *****		11. BIRTHPLACE (State or foreign country): Frederick, Co.	
13. FATHER'S NAME: Thomas Cartnail				14. MOTHER'S MAIDEN NAME: Hester Palmer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: 214-03-5981		17. INFORMANT & ADDRESS: Grace M. Cartnail, Harmony Grove... Haywood Rd. Fred, Co.			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
420.1 Immediate cause (a) Coronary Thrombosis DUE TO						1st	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arterio Sclerosis DUE TO						2nd	
(c)							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: 8				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 19 55, to June 7, 1955, that I last saw the deceased alive on June 7, 1955, and that death occurred at 3:00 PM, from the causes and on the date stated above.							
SIGNATURE B. Thomas MD				DATE SIGNED June 8, 1955			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		June 11, 1955		John Wesley		Libertytown, Fred. Co. Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
9 June 1955		Elizabeth S. Hick		Charles E. Hicks III		Frederick, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 13 1955

RECEIVED



5586

## CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Baltimore City</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <b>Cullen</b>		294 days.		TOWN <b>Baltimore</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Victor Cullen State Hospital</b>				STREET ADDRESS (If rural give location) <b>27 N. Carey Street</b>			
3. NAME OF DECEASED: (First) <b>Donald</b> (Middle) <b>MacDonald</b> (Last) <b>Christie</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>June 30 19 55</b>			
5. SEX: <b>Male</b>		6. COLOR OR RACE: <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>		8. DATE OF BIRTH: <b>5/9/1884</b>	
9 AGE last birthday <b>71</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>D.P.W. &amp; OAA closed May 1954</b>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <b>Kansas</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME: <b>William Longsdale Christie</b>				14. MOTHER'S MAIDEN NAME: <b>Frances Holt</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>219-05-5634A</b>		17. INFORMANT & ADDRESS: <b>Donald MacDonald Christie</b>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Acute Coronary occlusion</b>						1 week	
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <b>(002X)</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Pulmonary Tuberculosis</b>						1 year.	
19A. DATE OF OPERATION: <b>0</b>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (city or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Aug. 10</b> , 19 <b>54</b> , to <b>June 30</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>June 30</b> , 19 <b>55</b> , and that death occurred at <b>10 a.</b> M, from the causes and on the date stated above.							
SIGNATURE <b>[Signature]</b>		ADDRESS <b>Cullen, Maryland</b>		DATE SIGNED <b>July 1, 1955</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>7-11-55</b>		NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cem.</b>		LOCATION (City, town, or county) (State) <b>Thurmont, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>6/30/55</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		24. FUNERAL DIRECTOR		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. B.

JUL 5 1955

RECEIVED

05572

5587

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 147

Item 1 FilmG183 6/27/55 b

1. PLACE OF DEATH COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ed. Airy RD</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ed. Mt Airy</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>(Nr. Harrisville)</u>		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>LUCY</u> (First) <u>RAWLINGS</u> (Middle) <u>COWNES</u> (Last)		4. DATE OF DEATH (Month) <u>6</u> (Day) <u>19</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 28, 1878</u>
9. AGE last birthday <u>77</u> yrs.		10. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Calvin Rawlings</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Rawlings Acton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Mrs. C. W. Foster (Daughter)</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

156.1

## Immediate cause

(a)

## Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1955 to June 19, 1955, that I last saw the deceased alive on June 18, 1955 and that death occurred at 12:45 P.M. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

June 19, 1955Clarence A. KunkleW. W. Chambers517-11th St. S.E.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU V. S.

JUN 21 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Item 21 Film G183 7-6-55

MARYLAND STATE DEPARTMENT OF HEALTH

05573

# CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No. 131

5557

1. PLACE OF DEATH - COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <b>Maryland</b>		COUNTY <b>Frederick</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		LENGTH OF STAY (in this place) <b>10 yrs.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>121 Pennsylvania Ave.</b>				STREET ADDRESS (If rural, give location) <b>121 Pennsylvania Ave.</b>			
3. NAME OF DECEASED (Type or Print) <b>Betty</b>		(First) <b>Jane</b>		(Last) <b>Crawford</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>June 21 1955</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>		8. DATE OF BIRTH <b>5-13-1928</b>	
				9. AGE last birthday <b>27 yrs.</b>		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George E. Reynolds</b>				14. MOTHER'S MAIDEN NAME <b>Mary Steward</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-26-8755</b>		17. INFORMANT AND ADDRESS <b>Mr. John E. Crawford (husband)</b>		121 Pa. Ave. Fred'k. Md.	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

**Aspiration Asphyxia**

INTERVAL BETWEEN ONSET AND DEATH

**Mins.**

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>none</b>		PLACE (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		(CITY OR TOWN) <b>Frederick</b>		(COUNTY) <b>Fred.</b>		(STATE) <b>Md.</b>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>June 21, 1955 10:30 pm.</b>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? <b>Was laughing and regurgitated highly acid gastric fluid contents.</b>					

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

**Robert J. June, M.D., R.D.O.G., Frederick, Md. June 22, 1955**

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>6-24-1955</b>		NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		LOCATION (City, town, or county) <b>Frederick</b>		(State) <b>Maryland</b>	
DATE REC'D BY LOCAL REG. <b>23 June 1955</b>		REGISTRAR'S SIGNATURE <b>Elizabeth G. Heck</b>		24. FUNERAL DIRECTOR <b>C.E. Cline and Son-Frederick, Maryland</b>		ADDRESS			

BUREAU V. S.

JUN 24 1955

RECEIVED

5558

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Frederick</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Frederick</b>		LENGTH OF STAY (in this place) <b>Lifetime</b>		CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Frederick</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>614 Wilson Place</b>				STREET ADDRESS (If rural give location) <b>614 Wilson Place</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>GRACE ELEANOR CRUM</b>		4. DATE OF DEATH: (Month) (Day) (Year) <b>June 4 19 55</b>					
5. SEX: <b>Female</b>	6. COLOR OR RACE: <b>White</b>	7. <del>SINGLE, MARRIED, WIDOWED, DIVORCED,</del> <b>Married</b>	8. DATE OF BIRTH: <b>April 7, 1890</b>	9. AGE last birthday: <b>65</b> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>Own home</b>		11. BIRTHPLACE (State or foreign country): <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>Thomas M. Wachter</b>				14. MOTHER'S MAIDEN NAME: <b>Cynthia Measell</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY No.: <b>None</b>		17. INFORMANT & ADDRESS: <b>Mr. Glenn R. Crum - Frederick, Maryland</b>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>154X</b> <b>Immediate cause</b> (a) <b>Cancer of rectum with metastases.</b> <b>Antecedent causes (s)</b> (b) <b>DUE TO</b> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. <b>DUE TO</b> (c)				Interval Between Onset And Death <b>4 months</b>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <b>June 7, 1955</b>				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Jan 1955</b> , to <b>June 4, 1955</b> , that I last saw the deceased alive on <b>June 3, 1955</b> , and that death occurred at <b>11:00 A.M.</b> from the causes and on the date stated above. SIGNATURE <b>Robert Martin M.D.</b> ADDRESS <b>35 E. Church Frederick, Md</b>							
23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>June 7, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>June 1955</b>		REGISTRAR'S SIGNATURE <b>Elizabeth G. Heik.</b>		24. FUNERAL DIRECTOR ADDRESS <b>C. E. Cline &amp; Son - 8 East Patrick Street Frederick, Maryland</b>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BUREAU V. S.

JUN 8 1955



5559 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05575  
**CERTIFICATE OF DEATH** Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Frederick</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Frederick</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Frederick</b>	LENGTH OF STAY (in this place) <b>Since 1910</b>	CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>331 East Third Street</b>		STREET ADDRESS (If rural give location) <b>331 East Third Street</b>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) <b>NORMA</b>	(Middle) <b>EDNA</b>	(Last) <b>DARNER</b>	
		<b>June 19, 1955</b>	
5. SEX: <b>Female</b>	6. COLOR OR RACE: <b>White</b>	7. <del>SINGLE, MARRIED</del> <b>WIDOWED, DIVORCED</b> (Specify): <b>Widow</b>	8. DATE OF BIRTH: <b>20 Aug 1872</b>
		9. AGE last birthday <b>82</b> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>House-work</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>At Home</b>	11. BIRTHPLACE (State or foreign country): <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME: <b>Horatio Zittle</b>	
14. MOTHER'S MAIDEN NAME: <b>Charlotte Toms</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT & ADDRESS: <b>100 W. Church St., Sherman P. Bowers, Frederick, Maryland</b>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <b>Diabetes Mellitus</b>		<b>20 yrs.</b>
ANTECEDENT CAUSE (S)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>June 14, 1955</b> , to <b>June 14, 1955</b> , that I last saw the deceased alive on <b>June 14, 1955</b> , and that death occurred at <b>1:50A</b> M, from the causes and on the date stated above.					
SIGNATURE <b>H. Klein</b>		ADDRESS <b>Frederick, Maryland</b>		DATE SIGNED <b>20 June 1955</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>22 June 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>	
				LOCATION (City, town, or county) (State) <b>Middletown, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>21 June 1955</b>		REGISTRAR'S SIGNATURE <b>Elizabeth G. Hark</b>		24. FUNERAL DIRECTOR ADDRESS <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 22 1955

BUREAU V. S.

5560

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Frederick</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>11 Frederick</u>	LENGTH OF STAY (in this place) <u>20 dys</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Union Bridge-Rural- R. D. #2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>69 Frederick Mem. Hosp.</u>		STREET ADDRESS (If rural give location) <u>Near Libertytown</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Michael</u>	(Middle) <u>David</u>	(Last) <u>DeGrange</u>	DATE OF DEATH: <u>June 23 1955</u>
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>June 3, 1955</u>
9. AGE last birthday <u>20</u> yrs.		10. IF UNDER 1 YEAR: Months <u>20</u> Days <u>20</u> Hours <u>20</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY: <u>Infant</u>	
11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>John Luther DeGrange</u>		14. MOTHER'S MAIDEN NAME: <u>Burrier</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>9</u>		16. SOCIAL SECURITY NO. <u>Hosp. records</u>	
17. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>764.5 Ileitis, acute</u>			
ANTECEDENT CAUSE (S) DUE TO (B) <u>Sclerema</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Prematurity</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) (M.)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12 June 1955</u> , to <u>23 June 1955</u> , that I last saw the deceased alive on <u>22 June 1955</u> , and that death occurred at <u>4:35 A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>R L G West</u>		ADDRESS <u>Frederick</u> DATE SIGNED <u>23 June 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 24, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		LOCATION (City, town, or county) (State) <u>Middletown, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>23 June 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth J. Hark</u>	
24. FUNERAL DIRECTOR <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 27 1965

BUREAU V. S.

5561

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 11 Frederick		LENGTH OF STAY (in this place) Life		CITY (If outside corporate limits, write RURAL and give nearest town) OR Frederick			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 69 Frederick Memorial Hospital				STREET ADDRESS (If rural give location) 11 157 West Patrick Street			
3. NAME OF DECEASED: (First) (Middle) (Last) NINA GRACE DEVISS				4. DATE (Month) (Day) (Year) OF DEATH: June 6, 1955			
5. SEX: Female		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single		8. DATE OF BIRTH: 4 December 1890	
9. AGE last birthday: 64 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer		10B. KIND OF BUSINESS OR INDUSTRY: Laundry		11. BIRTHPLACE (State or foreign country): Maryland	
13. FATHER'S NAME: James Edward Devillbiss				14. MOTHER'S MAIDEN NAME: Laura Michael			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY NO. 214-10-3885		17. INFORMANT & ADDRESS: 265 W. Patrick St., Mrs. Helen F. Keller, Frederick, Maryland	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Pulmonary edema				hours			
ANTECEDENT CAUSE (S) (B) Coronary atherosclerosis				48 hours			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) Diabetes mellitus				years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 21				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6/5, 1955, to 6/6, 1955, that I last saw the deceased alive on 6/5, 1955, and that death occurred at 5:30A M, from the causes and on the date stated above.							
SIGNATURE James B. Thomas				ADDRESS Frederick, Maryland		DATE SIGNED 7 June 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 8 June 1955		NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		LOCATION (City, town, or county) (State) Frederick, Maryland	
DATE REC'D BY LOCAL REGISTRAR 8 June 1955		REGISTRAR'S SIGNATURE Elizabeth L. Hesch		24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland		ADDRESS	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JUN 9 1955

RECEIVED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

05538

Item 8, Film 182 6-20-55 et

## 1. PLACE OF DEATH:

COUNTY **Frederick**

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

**Frederick**

LENGTH OF STAY (in this place)

**7 days**

HOSPITAL OR INSTITUTION OR STREET ADDRESS

**Frederick Memorial Hospital**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Maryland**COUNTY **Montg**

CITY (If outside corporate limits, write RURAL and give nearest town)

OR

TOWN **Dickerson**

STREET ADDRESS

(If rural give location)

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

**Margaret****Eulia Fisk**

4. DATE OF DEATH:

(Month)

(Day)

(Year)

**June****10****19 55**

## 5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

**Female****White****Married****Feb. 25-1875****81**

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):

**House wife**

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

**Maryland**

12. CITIZEN OF WHAT COUNTRY?

**U.S**

## 13. FATHER'S NAME:

**Daniel Shreve**

## 14. MOTHER'S MAIDEN NAME:

**Margaret Jones**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

**None**

## 17. INFORMANT &amp; ADDRESS:

**Carroll Fisk, Dickerson Md**

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

**170X**

Immediate cause

(a) DUE TO

**Cancer of The Left Breast**

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

Interval Between Onset And Death

**3 years**

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY ?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED

While at Work ☐Not While At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from **June, 1950**, to **10 June, 1955**, that I last saw the deceasedalive on **9 June, 1955**, and that death occurred at **10 25 AM**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

**Edwin M. Smith****M.D.****Barnesville****10 June 55**

## 23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

**Barnesville Md**

ADDRESS

**11 June 1955****Elizabeth B. Heck****Wallace B. Nelson****Barnesville Md**

RECEIVED  
JUN 14 1955  
BUREAU V. S.



5563

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Frederick</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		LENGTH OF STAY (in this place) <u>Weeks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mt. Pleasant</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Three Pines Nursing Home</u>				STREET ADDRESS (If rural give location) <u></u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>ANNA</u> <u>MARY</u> <u>FLORA</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>June</u> <u>21</u> , <u>1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>October 9, 1875</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Charles S. Flora, Mt. Pleasant, Maryland</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinomatous</u>						<u>months</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from ..... , 1953 to <u>6/21</u> , 1955, that I last saw the deceased alive on <u>6/20</u> , 1955, and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James B. Thomas</u>				ADDRESS <u>Frederick, Maryland</u>		DATE SIGNED <u>6/22/1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 24, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Park Heights Cemetery</u>		LOCATION (City, town, or county) (State) <u>Brunswick, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>24 June 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>		24. FUNERAL DIRECTOR ADDRESS <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>			

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JUN 27 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5588

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 138

05580

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>FREDERICK</u>		MARYLAND		STATE <u>PENNA.</u>		COUNTY <u>BUTLER</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>BARTHOWS</u>		LENGTH OF STAY (in this place) <u>2 WEEKS</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>PROSPECT</u>		<u>75x3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MT. AIRY, RFD #1</u>				STREET ADDRESS (If rural, give location) <u>RFD #1</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>ROSIE</u>		(Middle) <u>NANCY</u>		(Last) <u>GRAHAM</u>		(Month) (Day) (Year) <u>JUNE 12, 1955</u>	
5. SEX: <u>FEMALE</u>		6. COLOR OR RACE: <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>		8. DATE OF BIRTH: <u>14 July 1892</u>	
9. AGE last birthday: <u>62</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country): <u>PENNA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME: <u>JOHN PATTERSON</u>			
14. MOTHER'S MAIDEN NAME: <u>ELIZABETH BLACK</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>			
16. SOCIAL SECURITY No.: <u>NONE</u>				17. INFORMANT & ADDRESS: <u>GEORGE L. GRAHAM, RTE1, PROSPECT, PA., HUSBAND</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>420.0</u> Immediate cause (a) <u>ACUTE CONGESTIVE HEART FAILURE</u> DUE TO Antecedent cause(s) (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						<u>20'</u>  <u>YRS.</u>	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>6</u>				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <u>NONE</u>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town)		(County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Robert J. June</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>6-12-55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>12 June 1955</u>		<u>Prospect-Butler County, Pa.</u>			
DATE REC'D BY LOCAL REG <u>12 June 1955</u>		REGISTRAR'S SIGNATURE <u>Lucian K. Falconer</u>		24. FUNERAL DIRECTOR ADDRESS <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>			

RECEIVED

JUN 16 1955

BUREAU V. S.

5564

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Frederick</b>	
CITY (If outside corporate limits, write RURAL or and give nearest town) <b>Frederick</b>		LENGTH OF STAY (in this place) <b>25 years</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>1306 West 7th Street</b>				STREET ADDRESS (If rural give location) <b>1306 West 7th Street</b>			
3. NAME OF DECEASED: (First) <b>ROY</b>		(Middle) <b>DILLER</b>		(Last) <b>HAHN</b>		4. DATE OF DEATH: (Month) <b>June</b> (Day) <b>25</b> (Year) <b>1955</b>	
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. <del>SINGLE</del> , MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>		8. DATE OF BIRTH: <b>December 24, 1904</b>		9. AGE last birthday: <b>50</b> yrs. If UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired. <b>Bus Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>Transportation</b>		11. BIRTHPLACE (State or foreign country): <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>James Hahn</b>				14. MOTHER'S MAIDEN NAME: <b>Laura Fogle</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY No.: <b>212-24-2871</b>		17. INFORMANT & ADDRESS: <b>Mrs. Roy D. Hahn - Frederick, Maryland</b>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>420.1</b> <b>Immediate cause</b> <b>Coronary Thrombus</b> <b>Antecedent causes (s)</b> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. <b>DUE TO</b>						Interval Between Onset And Death <b>2 months</b>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <b>June 29, 1955</b>				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) <b>INJURY</b>		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>June 25, 1955</b> , to <b>June 28, 1955</b> , that I last saw the deceased alive on <b>June 10, 1955</b> , and that death occurred at <b>10:30 P.M.</b> from the causes and on the date stated above. SIGNATURE <b>H. H. Kline Sr.</b> (Degree or title) DATE SIGNED <b>Frederick Md June 28 1955</b>							
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>June 29, 1955</b>		<b>Mount Olivet Cemetery</b>		<b>Frederick, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS			
<b>28 June 1955</b>		<b>Elizabeth G. Heck</b>		<b>C. E. Cline &amp; Son - 8 East Patrick Street Frederick, Maryland</b>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JUN 29 1955

RECEIVED

BUREAU V. S.

5565

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Frederick</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Frederick</u>		LENGTH OF STAY (in this place) Years		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Frederick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>100 West Fifth Street</u>				STREET ADDRESS (If rural give location) <u>100 West Fifth Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>SARAH</u> <u>CATHERINE</u> <u>HAMMOND</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>June 2, 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>		8. DATE OF BIRTH: <u>May 21, 1875</u>	
9. AGE last birthday: <u>80</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housework</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Emanuel Goins</u>				14. MOTHER'S MAIDEN NAME: <u>Emily DeMarr</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Mr. William A. Hammond, 70 Lincoln Apts., Frederick, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Ch. Cor. Renal Uremic chain</u>						3 y.	
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-2</u> , 19 <u>55</u> , to <u>6-2</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6-2</u> , 19 <u>55</u> , and that death occurred at <u>4:45 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>U. G. Baune Jr.</u>		M. D. <u>Frederick, Maryland</u>		DATE SIGNED <u>6/3/1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 6, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>9 June 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth G. Heath</u>		24. FUNERAL DIRECTOR ADDRESS <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>			

MARGIN RESERVED FOR BINDING



RECEIVED

JUN 8 1955

BUREAU V. S.



5566

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

## 1. PLACE OF DEATH:

COUNTY **Frederick**

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) **Frederick** LENGTH OF STAY (in this place) **1 week**HOSPITAL OR NURSING HOME  
INSTITUTION OR  
STREET ADDRESS **7 East 4th.St.**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Maryland**COUNTY **Frederick**CITY (If outside corporate limits, write RURAL and give nearest town) **Brunswick**

STREET ADDRESS (If rural give location)

**North Virginia Ave.**3. NAME OF DECEASED:  
(Type or Print)

(First)

**Anna**

(Middle)

**Mae**

(Last)

**Himes**

4. DATE

(Month)

(Day)

(Year)

OF DEATH:

**6****19****55**

## 5. SEX:

**Female**

## 6. COLOR OR

**White**

## 7. SINGLE, MARRIED,

**Widowed**

## 8. DATE OF BIRTH:

**9-15-1885**

## 9. AGE last birthday:

**69**

yrs.

## IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): **House wife**10b. KIND OF BUSINESS OR INDUSTRY: **Home**11. BIRTHPLACE (State or foreign country): **West Virginia**12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

## 13. FATHER'S NAME:

**Richard Wise**

## 14. MOTHER'S MAIDEN NAME:

**Eliza Carpenter**15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) **No**

## 16. SOCIAL SECURITY No.:

**-**

## 17. INFORMANT &amp; ADDRESS:

**Thomas M. Tucker, Jefferson, Maryland**

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

**331X**  
**Immediate cause**(a) **Cerebral vascular accident**

DUE TO

Antecedent causes (s)  
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.(b) **Generalized + cerebral arteriosclerosis**

DUE TO

(c)

Interval Between Onset And Death

**1 yr.****years.**

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY ?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from **6-18**, 19**55**, to **6-19**, 19**55**, that I last saw the deceasedalive on **6-18**, 19**55**, and that death occurred at **5:45 AM**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, etc.

**Burial**

## DATE THEREOF

**6-22-55**

## NAME OF CEMETERY OR CREMATORY

**St. Lukes**

## LOCATION (City, town, or county) (State)

**Brownsville, Wash. Co., Md.**

DATE REC'D BY LOCAL REGISTRAR

**22 June 1955**

## REGISTRAR'S SIGNATURE

**Elizabeth G. Hech.**

## 24. FUNERAL DIRECTOR

## ADDRESS

**C.H. Feete and Bro. Brunswick, Md.**

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JUN 24 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5589

CERTIFICATE OF DEATH

Reg. Dist. No.

05584

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b> COUNTY <b>Frederick</b>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR <b>Rural Harney</b>		LENGTH OF STAY (in this place) <b>65 yrs.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <b>Rural Harney</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00</b>				STREET ADDRESS (If rural give location) <b>1</b>			
3. NAME OF DECEASED: (First) <b>Flem</b> (Middle) <b>Hoffman</b> (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <b>June 13 1955</b>			
5. SEX: <b>Male</b>		6. COLOR OR RACE: <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Widowed</b>		8. DATE OF BIRTH: <b>July 21, 1870</b>	
9. AGE last birthday: <b>84</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Farmer</b>		11. BIRTHPLACE (State or foreign country): <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>Alexander Hoffman</b>				14. MOTHER'S MAIDEN NAME: <b>Sarah Walters</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT & ADDRESS: <b>George W. Hoffman, Route #1 Gettysburg, Pa.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>arteriosclerotic cardiovascular disease</b>							
ANTECEDENT CAUSE (B) <b>4221</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <b>0</b>				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Jan 10, 1955</b> to <b>June 13, 1955</b> , that I last saw the deceased alive on <b>June 10, 1955</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>W. R. Osale</b>				ADDRESS <b>Gettysburg, Pa.</b>		DATE SIGNED <b>6-13-55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>6/16/55</b>		NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		LOCATION (City, town, or county) (State) <b>Harney, Carroll, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>June 13 1955</b>		REGISTRAR'S SIGNATURE <b>M. F. Shuff</b>		24. FUNERAL DIRECTOR <b>C.O. Fuss &amp; Son, Taneytown, Maryland</b>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 16 1955

BUREAU V. S.

5567

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		06X-2	
11 TOWN <u>Frederick</u>		3 days		TOWN <u>Lansy town</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: <u>MAMIE E. HOUCK</u>				OF DEATH: <u>June 21 1955</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>July 7, 1875</u>	9. AGE last birthday: <u>79</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Seamstress</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Clothing mfg. Co.</u>	11. BIRTHPLACE (State or foreign country): <u>md</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Wilford A. Renner</u>				14. MOTHER'S MAIDEN NAME: <u>Martha Derr</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>215-03-3531</u>		17. INFORMANT & ADDRESS: <u>Mr. Bruce A. Houck, 616 Middle St., Fred.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
584X IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u>						3 hrs	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Stroke is common like duck</u>						6 days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>+ pertussis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>21</u>				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 15, 1955</u> , to <u>June 21, 1955</u> , that I last saw the deceased alive on <u>June 20, 1955</u> , and that death occurred at <u>1:00 A M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Bl. H. H. H.</u>				ADDRESS <u>Frederick md</u>		DATE SIGNED <u>6/22/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/23/55</u>		NAME OF CEMETERY OR CREMATORY <u>mt hope</u>		LOCATION (City, town, or county) (State) <u>Woodsboro md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>22 June 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth S. Heck</u>		24. FUNERAL DIRECTOR <u>G. C. Barton, Walkersville, md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 24 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05586

5568

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Frederick	MARYLAND	STATE Maryland	COUNTY Baltimore
CITY (If outside corporate limits, write RURAL OR and give nearest town) 11 Frederick	LENGTH OF STAY (in this place) Since 5/6/46	CITY (If outside corporate limits, write RURAL and give nearest town) OR Dundalk 53X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 I. O. O. F. Home		STREET ADDRESS (If rural give location) Dogwood Road near Wise Avenue ✓	
3. NAME OF DECEASED: (First) (Middle) (Last) ANNA INNIS		4. DATE (Month) (Day) (Year) OF DEATH: June 13, 1955	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow	8. DATE OF BIRTH: 3 August 1874
9. AGE last birthday: 80 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House-work		10B. KIND OF BUSINESS OR INDUSTRY: I. O. O. F. Home	
11. BIRTHPLACE (State or foreign country): Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Henry Harman Deisreth		14. MOTHER'S MAIDEN NAME: Mary Corlee	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) 4 No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS: I. O. O. F. Home Records			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 IMMEDIATE CAUSE (A) Coronary occlusion			
ANTECEDENT CAUSE (S) (B) Chronic myocarditis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1-1-1953 to 6-13-1955 that I last saw the deceased alive on 6-13-1955, and that death occurred at 10 P M, from the causes and on the date stated above.			
SIGNATURE J. M. Smith		ADDRESS M. D. Frederick, Maryland	
DATE SIGNED 13 June 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 16 June 1955	
NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park		LOCATION (City, town, or county) (State) Nr. Glen Burnie, Maryland	
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland		ADDRESS	



BUREAU V. S.

JUN 16 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 195587

5590

CERTIFICATE OF DEATH

Reg. Dist. No. 144

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Md</b>		COUNTY <b>Frederick</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Rural Thurmont</b>		LENGTH OF STAY (In this place) <b>5 yrs.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Rural Thurmont</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00</b>				STREET ADDRESS (If rural give location) <b>1</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>George Staley Jacobs</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>June 7. 1955</b>			
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH: <b>Feb. 27th. 1925</b>	9. AGE last birthday <b>30</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine Operator</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Cannon Shoe Co</b>		11. BIRTHPLACE (State or foreign country): <b>Frederick Co Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>George F. Jacobs</b>				14. MOTHER'S MAIDEN NAME: <b>Myrtle M. Danner</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-24-9249</b>		17. INFORMANT & ADDRESS: <b>Mary Louise Jacobs Thurmont. Md</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
260X IMMEDIATE CAUSE		(A) <b>Diabetes Mellitus</b>				5 yrs.	
ANTECEDENT CAUSE (B)		DUE TO					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) DUE TO					
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <b>None</b>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) OF INJURY <b>None</b>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>June 1—</b> , 19 <b>55</b> to <b>June 7</b> , 19 <b>55</b> that I last saw the deceased alive on <b>June 7—</b> , 19 <b>55</b> , and that death occurred at <b>5:30PM</b> , from the causes and on the date stated above.							
SIGNATURE <b>James K. Gray</b>		ADDRESS <b>M.D. Thurmont. Md.</b>		DATE SIGNED <b>June 8-1955</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>June 10. 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Rocky Hill Cem.</b>		LOCATION (City, town, or county) (State) <b>Near Woodsboro MD</b>	
DATE REC'D BY LOCAL REGISTRAR <b>June 10, 1955</b>		REGISTRAR'S SIGNATURE <b>Blanche S. Eyles</b>		24. FUNERAL DIRECTOR <b>M.L. Creager &amp; Son</b>		ADDRESS <b>Thurmont Md</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

7590

BUREAU V. 2

JUN 13 1955

RECEIVED

5569

MARYLAND STATE DEPARTMENT OF HEALTH

05588

Item 18 Film G183 7-6-55

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 131

1. PLACE OF DEATH COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>108 N. Bentz St.</u>		STREET ADDRESS (If rural, give location) <u>108 N. Bentz St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>HELEN</u>	(Middle) <u>LOUISE</u>	(Last) <u>JOHNSON</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>24 July 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse's Aide</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>	9. AGE last birthday <u>65</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas S. Eader</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Ebert</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-34-2469</u>	
17. INFORMANT AND ADDRESS <u>Richard D. Johnson, Sparks, Maryland</u>			

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4200

Immediate cause

(a) Congestive heart failure

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerotic heart disease

(c)

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☒ No ☐21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Robert J. Jure, M.D., R.D.D., Frederick, Md. 6-17-55

## 23. BURIAL, CREMATION, or other disposal (Specify)

Burial

## DATE THEREOF

20 June 1955

## NAME OF CEMETERY OR CREMATORY

Mount Olivet Cemetery

## LOCATION (City, town, or county)

Frederick, Maryland

(State)

## DATE REC'D BY LOCAL REG.

20 June 1955

## REGISTRAR'S SIGNATURE

Elizabeth B. Heck

## 24. FUNERAL DIRECTOR

M. R. Etchison & Son, Frederick, Maryland

## ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED

JUN 22 1955

BUREAU V. S.

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

5591

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Frederick</u> MARYLAND	STATE <u>Md.</u> COUNTY <u>Frederick</u>		
<del>CITY</del> (If outside corporate limits, write RURAL and give nearest town)	<del>CITY</del> (If outside corporate limits, write RURAL and give nearest town)		
TOWN <u>Rural Frederick</u> LENGTH OF STAY (in this place) <u>3 hrs.</u>	TOWN <u>Middletown</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location)		
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>Charles Ernest Keller</u>		<u>June 5, 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. <del>SINGLE</del> , MARRIED, <del>WIDOWED</del> , <del>DIVORCED</del> (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Oct. 18, 1886</u>
9. AGE last birthday: <u>68</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Stock Clerk - Plumbing</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Middletown Md.</u>	
11. BIRTHPLACE (State or foreign country): <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>John C. Keller</u>		14. MOTHER'S MAIDEN NAME: <u>Antie Remsberg</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-14-6824</u>	
17. INFORMANT & ADDRESS: <u>Charles E. Keller Jr. Frederick Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<u>35 min.</u>	
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>			
ANTECEDENT CAUSE (B) <u>(1) Myocardial infarction</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>Heart Block</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>6-5-55</u> , 19 <u>55</u> to <u>6-5-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6-5-55</u> , 19 <u>55</u> , and that death occurred at <u>7:05 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>J. E. Harp</u>		DATE SIGNED <u>6-6-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Burial</u>		DATE THEREOF: <u>6-7-55</u>	
NAME OF CEMETERY OR CREMATORY: <u>Reform Cem.</u>		LOCATION (City, town, or county) (State): <u>Middletown, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>6 June 1955</u>		REGISTRAR'S SIGNATURE: <u>Elizabeth B. Harb.</u>	
24. FUNERAL DIRECTOR: <u>Gladhill Co.</u>		ADDRESS: <u>Middletown</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUN 8 1955  
BUREAU V. S.



Item 8, Film 183 6-27-55 et

5570

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Frederick</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Frederick</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Frederick</b>	LENGTH OF STAY (in this place) <b>Life</b>	CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>306 East Third Street</b>		STREET ADDRESS (If rural give location) <b>306 East Third Street</b>	
3. NAME OF DECEASED: (First) (Middle) (Last) <b>LILLIAN ALICE KLINE</b>		4. DATE (Month) (Day) (Year) OF DEATH: <b>June 17, 1955</b>	
5. SEX: <b>Female</b>	6. COLOR OR RACE: <b>White</b>	7. <del>SINGLE</del> , <del>MARRIED</del> , <del>WIDOWED</del> , <del>DIVORCED</del> . (Specify): <b>Widow</b>	8. DATE OF BIRTH: <b>28 Aug 1886/1884</b>
9. AGE last birthday <b>70</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>House-work</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>At Home</b>	
11. BIRTHPLACE (State or foreign country): <b>Frederick, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>Clayton Fout</b>		14. MOTHER'S MAIDEN NAME: <b>Mary Alice Hoffman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY No. <b>None</b>	
17. INFORMANT & ADDRESS: <b>Mrs. Guy L. Ernest, RD#6, Frederick, Md.</b>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <b>350X</b>		<b>10 days</b>	
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		<b>5 years</b>	
(A) DUE TO <b>Broncho-pneumonia</b>		<b>6 weeks</b>	
(B) DUE TO <b>Parkinson's disease</b>			
(C) DUE TO <b>Decubitus ulcers</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Jan 1, 1952</b> , to <b>June 17, 1955</b> , that I last saw the deceased alive on <b>June 17, 1955</b> , and that death occurred at <b>12:30 PM</b> , from the causes and on the date stated above.			
SIGNATURE <b>Bernard O. Flum</b>		ADDRESS <b>Frederick, Maryland</b>	
DATE SIGNED <b>18 June 1955</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>20 June 1955</b>	
NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>20 June 1955</b>		REGISTRAR'S SIGNATURE <b>Elizabeth B. Hede</b>	
24. FUNERAL DIRECTOR <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 22 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# 5592 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05591  
 Reg. Dist.

No. 131

## 1. PLACE OF DEATH:

COUNTY FREDERICK MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) NR. FREDERICK LENGTH OF STAY (in this place) 2 YRS.  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS EN ROUTE FRED. MEM. HOSP.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY FREDERICK  
 CITY (If outside corporate limits write RURAL and give nearest town) RURAL - HYATTSTOWN  
 STREET ADDRESS (If rural, give location) 1

## 3. NAME OF DECEASED:

(First) LUCILLE (Middle) ELIZABETH (Last) MATHERS

4. DATE OF DEATH (Month) (Day) (Year)  
JUNE 15, 1955

## 5. SEX:

FEMALE

## 6. COLOR OR RACE:

NH 10E

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: 1919 9. AGE last birthday: 35 36 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.  
 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: AT HOME

11. BIRTHPLACE (State or foreign country): DISTRICT OF COLUMBIA

12. CITIZEN OF WHAT COUNTRY? USA

## 13. FATHER'S NAME:

CRAIG ANDERSON

## 14. MOTHER'S MAIDEN NAME:

RUTH N. HOOVER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: HUSBAND - CLAUDE MATHERS - SAME ADDRESS.

## 18. MEDICAL CERTIFICATION

### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a) Air & Water Embolism

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

Mins.

### II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

Pregnancy, 2 1/2 mos. approx.

### 19a. DATE OF OPERATION:

### 19b. MAJOR FINDING OF OPERATION:

### 20. AUTOPSY?

Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Home

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY June 15, 1955 11:30 PM

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR? Attempt at self-induction of labor with rubber catheter, ear syringe & water.

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

Robert J. Julie

CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED 6-15-55

### 23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF 6-17-55

NAME OF CEMETERY OR CREMATORY Arlington National

LOCATION (City, town, or county) Arlington, Va.

(State)

DATE REC'D BY LOCAL REG. 15 June 1955

REGISTRAR'S SIGNATURE Elizabeth B. Hech

24. FUNERAL DIRECTOR Robert A. Peirce, Bethesda Md.

ADDRESS

BUREAU V. S.

JUN 16 1935

RECEIVED

5571

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

## 1. PLACE OF DEATH:

COUNTY FREDERICK

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

FREDERICK

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

FREDERICK MEMORIAL HOSPITAL

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MarylandCOUNTY Howard

CITY (If outside corporate limits, write RURAL and give nearest town)

OR

TOWNRural- Ridgeville13X-2

STREET ADDRESS

(If rural give location)

R.F.D. Mt. Airy

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

JamesWilliamMOLESWORTH

## 5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, SPECIFY

8. DATE OF BIRTH:

4. DATE OF DEATH:

(Month)

(Day)

(Year)

JUNE 121955MaleWhiteSingleOct. 29, 189856

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired

10b. KIND OF BUSINESS OR INDUSTRY:

Country Produce Salesman

11. BIRTHPLACE (State or foreign country):

Howard Co. Md.

12. CITIZEN OF WHAT COUNTRY?

USA

## 13. FATHER'S NAME:

James F. Molesworth

## 14. MOTHER'S MAIDEN NAME:

Lucy Virginia Brashears

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

## 16. SOCIAL SECURITY No.:

215-32-5800

## 17. INFORMANT &amp; ADDRESS:

Mrs James F. Molesworth, Mt. Airy, Md.

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

241X  
Immediate cause

(a)

ACUTE CORONARY THROMBOSIS

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

CHRONIC BRONCHITIS

DUE TO

(c)

CHRONIC BRONCHIAL ASTHMA

Interval Between Onset And Death

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED

While at Work

Not While At Work

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/12, 1955, to 6/12, 1955, that I last saw the deceasedalive on JUNE 12, 1955, and that death occurred at 11:45 PM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL

(Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

14 June 1955Elizabeth B. HerbOlin E. Molesworth, Damascus, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 16 1955

RECEIVED

5572

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i># rederrick</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Fredrick</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Rederrick</i>		LENGTH OF STAY (in this place) <i>25 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Thurmont R.D.</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Rederrick Memorial Hospital</i>				STREET ADDRESS (If rural give location) <i>1</i>			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First) <i>Margie</i>		(Middle) <i>H.</i>		(Last) <i>Myers</i>		(Month) (Day) (Year) <i>June 15 1955</i>	
5. SEX: <i>Female</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Widow</i>		8. DATE OF BIRTH: <i>Oct 24 1874</i>	
9. AGE last birthday: <i>80</i> yrs.		10. MONTHS: <i>80</i>		11. DAYS: <i>80</i>		12. HOURS: <i>80</i>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY: <i>Home</i>			
11. BIRTHPLACE (State or foreign country): <i>Oil City, Penna</i>				12. CITIZEN OF WHAT COUNTRY: <i>U.S.A.</i>			
13. FATHER'S NAME: <i>John J. Oberlin</i>				14. MOTHER'S MAIDEN NAME: <i>Mary Jane Randall</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>				16. SOCIAL SECURITY No.: <i>no</i>			
17. INFORMANT'S ADDRESS: <i>Charles Myers, Thurmont - R.D.</i>							
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
420.0 Immediate cause (a) <i>Congestive Heart Failure</i>						6 months	
Antecedent causes (s) (b) <i>Nephrosclerosis</i>						6 months	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <i>Arteriosclerosis Heart Disease</i>						3 years	
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <i>0</i>							
19b. MAJOR FINDINGS OF OPERATION							
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>3:20/449</i> , 1955, to <i>15 June</i> , 1955, that I last saw the deceased alive on <i>15 June</i> , 1955, and that death occurred at <i>9:12 A.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>Thomas E. Stone</i>		(Degree or title) <i>M.D.</i>		ADDRESS <i>443 rd St</i>		DATE SIGNED <i>6-15-55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>June 17 - 1955</i>		NAME OF CEMETERY OR CREMATORY <i>Blue Ridge Cem</i>		LOCATION (City, town, or county) (State) <i>Thurmont, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>16 June 1955</i>		REGISTRAR'S SIGNATURE <i>Elizabeth B. Heck</i>		24. FUNERAL DIRECTOR <i>M. J. Creagar &amp; Son</i>		ADDRESS <i>Thurmont, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

JUN 20 1955

BUREAU V. S.

05594

## MARYLAND STATE DEPARTMENT OF HEALTH

5593

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 131

1. PLACE OF DEATH- COUNTY <b>Frederick</b> STATE <b>MARYLAND</b>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Pennsylvania</b> COUNTY <b>York</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <b>TOWN</b> <b>Rural- E. of Frederick</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>York</b>	
HOSPITAL OR INSTITUTE OR STREET ADDRESS <b>Grove Quarry</b>		STREET ADDRESS (If rural give location) <b>401 West Market Street</b>	
3. NAME OF DECEASED (Type or Print) <b>Jack</b> (First) <b>E.</b> (Middle) <b>Nye</b> (Last)		4. DATE OF DEATH <b>June 7</b> (Month) <b>1955</b> (Year)	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Single</b>	8. DATE OF BIRTH <b>April 22-1930</b>
9. AGE last birthday <b>25</b> yrs.		10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Quarry Driller</b>		11b. KIND OF BUSINESS OR INDUSTRY	
12. FATHER'S NAME <b>Charles W. Nye</b>		13. MOTHER'S MAIDEN NAME <b>Eldem M. Simmons</b>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		15. SOCIAL SECURITY No.	
16. INFORMANT <b>General Director</b>		17. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>910.2</b> <b>Immediate cause</b> <b>(a) CRUSHED AND RUPTURED THORAX, FRACTURED SPINE, DEPRESSED FRACTURE OF SKULL</b> <b>Antecedent cause(s)</b> <b>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</b> <b>(c)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>INST.</b>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <b>June 7, 1955</b>		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY <b>ROCK QUARRY</b>	
TIME (Month) (Day) (Year) (Hour) INJURY <b>JUNE 7, 1955 7:50 p.m.</b>		HOW DID INJURY OCCUR? <b>CRUSHED BY ROCK FALL IN ROCK QUARRY</b>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <b>Robert J. Jure, M.D., Route 6, Frederick, Md.</b>		DATE SIGNED <b>6-7-55</b>	
23. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		DATE THEREOF <b>June 7-55</b>	
NAME OF CEMETERY OR CREMATORY <b>York- Pennsylvania</b>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <b>7 June 1955</b>		24. FUNERAL DIRECTOR <b>C.E.Cline and Son- Frederick- Md.</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 9 1955

BUREAU V. S.

5573

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <b>FREDERICK</b>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <b>Frederick</b>		LENGTH OF STAY (In this place) <b>2 hrs.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Baltimore</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Frederick Mem. Hospital</b>				STREET ADDRESS <b>5306 Norwood Avenue</b>	
3. NAME OF DECEASED (Type or Print) <b>ROSE</b>		(First) <b>T</b> (Middle)		(Last) <b>O'CONNOR</b>	
4. DATE OF DEATH (Month) <b>JUNE</b> (Day) <b>4</b> (Year) <b>1955</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>April 26, 1892</b>		9. AGE last birthday <b>63</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nursing</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		13. FATHER'S NAME <b>FRANCIS X. TIDDY</b>		14. MOTHER'S/MAIDEN NAME <b>LUCY E. MARTER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS <b>L. E. O'CONNOR 5306 Norwood Ave</b>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

**816X**  
Immediate cause

(a) **Surgical Shock (Traumatic)**

INTERVAL BETWEEN ONSET AND DEATH

**2 hrs.**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **Lacerated lung due to fractured ribs**

(c) **Cerebral Concussion**

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☒ No ☐

## 21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.)  
INJURY **Highway**

(CITY OR TOWN) **M. Lisbon** (COUNTY) **Carroll** (STATE) **Maryland**

TIME (Month) (Day) (Year) (Hour) OF INJURY **June 4, 1955 10:30 a.m.**

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? **Two automobile collision**

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

**Robert J. Janie, M.D., Box 236 RFD 6, Frederick, Md. 6-4-55**

## 23. BURIAL, CREMATION

REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

## DATE REC'D BY LOCAL

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

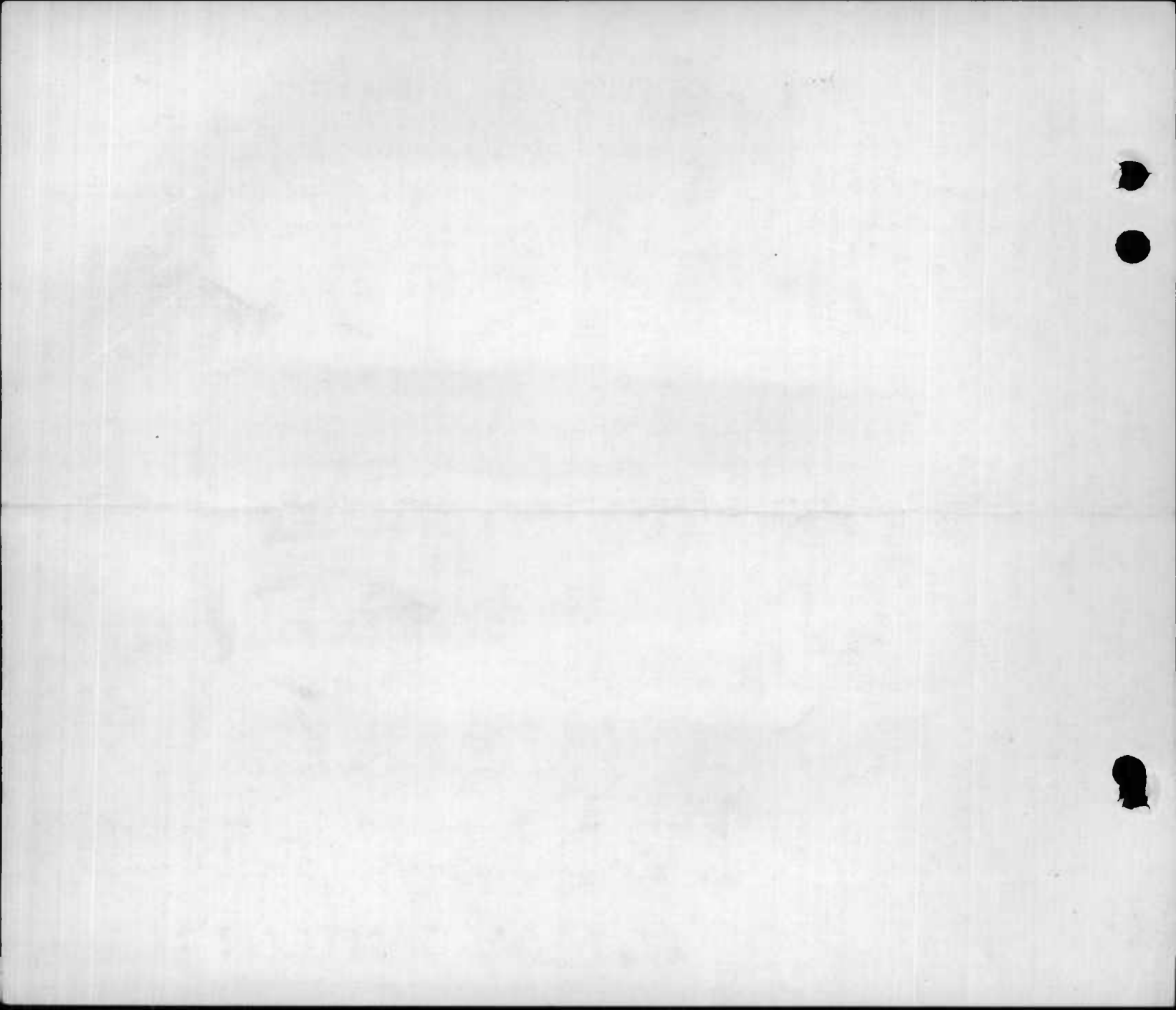
ADDRESS

**6-6-55** **Dr. W. Nedrick** **CHARLES F. EVANS & SON**

**118 W. ME. Royal Ave**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



5594

## CERTIFICATE OF DEATH

Reg. Dist. No. 139 05596

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>FREDERICK</u>	MARYLAND	STATE <u>MD.</u>	COUNTY <u>FREDERICK</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>SABILLESVILLE</u>	
<u>X</u> TOWN <u>SABILLESVILLE</u>	<u>41 YEARS</u>	<u>X</u> STREET ADDRESS (If rural give location) <u>Post Office Box</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			

3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
DECEASED: <u>David Eber Overcash</u>				OF DEATH: <u>JUNE 30 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>AUG. 17, 1888</u>	<u>66</u> yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>FARMER</u>		<u>SELF EMPLOYED</u>		<u>CHAMBERSBURG, PA. R#5</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:		12. CITIZEN OF WHAT COUNTRY?	
<u>REUBEN OVERCASH</u>		<u>ELIZABETH SPEILMAN</u>		<u>U. S. A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u># NO.</u>				<u>Robert C. Overcash, Sablesville, Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>160X</u>		<u>4 WEEKS</u>
ANTECEDENT CAUSE (S) <u>IN ANITATION</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>CARCINOMA of Rt. Nostril</u>		<u>1 YEAR</u>
(C) <u>CARCINOMA of STOMACH</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<u>0</u>		

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JAN., 1953 to JUNE 30., 1955, that I last saw the deceased alive on 6-30-55, 1955, and that death occurred at 8:15 P.M. from the causes and on the date stated above.

SIGNATURE <u>Ross L. Trunch</u>	DATE SIGNED <u>M. D. 117 W. Main St. Waynesboro Pa. 7-2-55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>7/3/55</u>
NAME OF CEMETERY OR CREMATORY <u>GREEN HILL</u>	LOCATION (City, town, or county) (State) <u>WAYNESBORO, PA.</u>
DATE REC'D BY LOCAL REGISTRAR <u>7/7/55</u>	REGISTRAR'S SIGNATURE <u>W. Lyon</u>
24. FUNERAL DIRECTOR <u>Stallin &amp; Gove</u>	ADDRESS <u>SECOND &amp; BROAD ST. WAYNESBORO, PA.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 2 1955

BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

05597

5595

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 145-

1. PLACE OF DEATH- COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Thyreville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Frederick</u>	
TOWN <u>Thyreville</u>		TOWN <u>Frederick</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>RDD 6</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>PAUL</u> (Middle) <u>JOHN</u> (Last) <u>PATTISON</u>		4. DATE OF DEATH (Month) <u>JUNE</u> (Day) <u>16</u> , (Year) <u>1955</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>DEC. 23, 1916</u>
9. AGE last birthday <u>38</u> yrs.		10. If under 1 year: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Mins. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Standard Engineering</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Camp Detrick</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George T. Pattison</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY No. <u>705-12-4456</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Charlotte Pattison, Baltimore, Md.</u>			

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>Carbon Monoxide Poisoning</u>		<u>None</u>
(b) Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause, stating the underlying cause last		
(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
--	--

19a. DATE OF OPERATION <u>June 16, 1955</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
---	----------------------------------	--

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Mountain Forest in Thyreville - Frederick - Md.</u>	(CITY OR TOWN) <u>Thyreville</u> (COUNTY) <u>Frederick</u> (STATE) <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>June 16, 1955</u> ? m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Piped exhaust into his station wagon</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☒ homicide ☐ undetermined ☐.

SIGNATURE Robert J. June, M.D., Box 236 RDD 6, Frederick, Md. DATE SIGNED 6-19-55

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial June 21, 1955</u>	DATE THEREOF	NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>	LOCATION (City, town, or county) <u>Baltimore, Maryland</u>	(State) <u>Md.</u>
--	--------------	--	---	--------------------

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>June 21, 1955</u> <u>Flay M. Bittle</u>	24. FUNERAL DIRECTOR <u>Singleton Funeral Home, Glen Burnie, Md.</u>
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 23 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 05598  
5596 CERTIFICATE OF DEATH

Reg. Dist. No. 144

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Frederick</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X <b>Rural-Thurmont</b>		<b>49 yrs.</b>		X <b>Rural-Thurmont</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<b>Route # 1</b>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<b>LESTER JOSEPH PENWELL</b>				<b>June 3 1955</b>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
<b>Male</b>	<b>White</b>	<b>Married</b>	<b>Oct. 2, 1905</b>	<b>49</b> yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life.)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<b>Aircraft Worker</b>		<b>Fairchild's</b>		<b>Thurmont Fred. Co. Md.</b>		<b>U.S.A.</b>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<b>George L. Penwell</b>				<b>Edith Stitley</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<b>no</b>				<b>213-18-9191</b>		<b>Mrs. Robert Gelwick, Thurmont, Md.</b>	
15. MEDICAL CERTIFICATION				Rt. #1			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE				3 mo.			
ANTECEDENT CAUSE (S):				1 yr.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
(A) <b>Carcinomatosis</b>							
DUE TO							
(B) <b>Adenocarcinoma of pancreas</b>							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YEB <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>5/2/55</b>		<b>Carcinomatosis</b>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Nov. 1, 1954</b> , to <b>June 4, 1955</b> , that I last saw the deceased alive on <b>June 3, 1955</b> , and that death occurred at <b>10:49 PM</b> from the causes and on the date stated above.							
SIGNATURE <b>M. Frank Bink</b>		M. D. <b>Thurmont Md.</b>		DATE SIGNED <b>6/4/55</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>June 7, 1955</b>		<b>Blue Ridge</b>		<b>Thurmont, Fred. Co. Md.</b>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<b>June 7 1955</b>		<b>Blauche S. Eyles</b>		<b>M.L. Creager &amp; Son, Thurmont, Md.</b>			

RECEIVED

5597

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick MARYLAND				STATE Maryland COUNTY Frederick			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Point of Rocks				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Point of Rocks			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year) OF DEATH:			
(First) (Middle) (Last) BETTIE ELIZABETH PEOMROY				June 18, 19 55			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Female		White		Widow		1 June 1878	
9. AGE last birthday		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
77 yrs.		House-work		Virginia		USA	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
James Jenkins				Eliza Waddell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
No				None		Miss Mammie Peomroy, Point of Rocks, Md.	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.0 IMMEDIATE CAUSE (A) <del>Art</del> Congestive Failure						6 max.	
ANTECEDENT CAUSE (S) (B) Arterio-sclerotic heart dis.						10 yrs ±	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
0							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from Jan, 19 55, to 18 June, 19 55, that I last saw the deceased alive on 16 June, 19 55, and that death occurred at 11 AM, from the causes and on the date stated above.							
SIGNATURE Charles H. Conley Jr.				DATE SIGNED 20 June 1955			
ADDRESS M. D. Frederick, Maryland							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		21 June 1955		St. Pauls Cemetery		Point of Rocks, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
21 June 1955		Elizabeth G. Hark		M. R. Etchison & Son, Frederick, Maryland			

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JUN 22 1955

RECEIVED



5574

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Frederick</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Frederick</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Frederick Memorial Hospital</b>				STREET ADDRESS (If rural give location) <b>223 West Patrick Street</b>			
3. NAME OF DECEASED: (First) <b>HAROLD</b> (Middle) <b>STANLEY</b> (Last) <b>PHEBUS</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>June 2, 1955</b>			
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Single</b>	8. DATE OF BIRTH: <b>2 June 1955</b>	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Infant</b>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>Walter Henry Phebus, Jr.</b>				14. MOTHER'S MAIDEN NAME: <b>Dorothy May Renner</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT & ADDRESS: <b>223 W. Patrick St., Walter H. Phebus, Jr., Frederick, Md.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Premature 5 1/2 month</b>							
ANTECEDENT CAUSE (S) (B) <b>Premature Eclampsia of Placenta</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <b>0</b>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>June 2, 1955</b> , to <b>June 2, 1955</b> , that I last saw the deceased alive on <b>June 2, 1955</b> , and that death occurred at <b>3:30 P.</b> from the causes and on the date stated above.							
SIGNATURE: <b>Thelma Fabray</b>		ADDRESS: <b>Frederick, Maryland</b>		DATE SIGNED: <b>3 June 1955</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>3 June 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR: <b>3 June 1955</b>		REGISTRAR'S SIGNATURE: <b>Elizabeth S. Heck-</b>		24. FUNERAL DIRECTOR ADDRESS: <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

JUN 8 1955

BUREAU V. S.

5598

## CERTIFICATE OF DEATH

Reg. Dist. No. 134

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Penna.		COUNTY Columbia	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN RDI Emmitsburg		4 days		Locust Dale		75X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
94 Mt-St Marys College				✓			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH:		(Month) (Day) (Year)	
(Type or Print) Francis		Pohl		JUNE		10 1955	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Single		72 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
		Catholic Priest		Johnstown Penna.		U. S.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Unknown				Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
Unknown		None		Fr Anthony Kane Gettysburg Pa.			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
420.1 Immediate cause						1/2 hour	
(a) Coronary occlusion							
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.						years.	
(b) Anteriosclerotic Cardiovascular disease							
(c)							
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
0							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
		INJURY					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
		m.					
22. I hereby certify that I attended the deceased from ..... 19....., to ..... 19....., that I last saw the deceased alive on ..... 19....., and that death occurred at 9:30 AM, from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
Charles R Williams MD				Emmitsburg Md June 10, 1955			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		June 14 1955		St. Ignatius Cemetery		Centralia Columbia Co. Pa.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
June 10-1955		M. F. Shuff		J. M. Sander		Gettysburg Penna.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 15 1955

RECEIVED

5575

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

## 1. PLACE OF DEATH:

COUNTY **Frederick**

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)  
OR **Frederick**LENGTH OF STAY  
(in this place)  
**4 years**HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS **701 Rosemont Avenue**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Maryland**COUNTY **Frederick**CITY (If outside corporate limits, write RURAL and give nearest town)  
OR **Frederick**STREET  
ADDRESS (If rural give location)**701 Rosemont Avenue**3. NAME OF  
DECEASED:  
(Type or Print)

(First)

**JAMES**

(Middle)

**ARUNAH**

(Last)

**ROGERS**4. DATE  
OF  
DEATH:

(Month)

(Day)

(Year)

**June 11 19 55**

## 5. SEX:

6. COLOR OR  
RACE:7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify): **Married**

## 8. DATE OF BIRTH:

9. AGE last birthday: **59** yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.  
Months Days Hours Min.10a. USUAL OCCUPATION. Give kind of  
work done during most of working life,  
even if retired): **Contractor**10b. KIND OF BUSINESS OR  
INDUSTRY:**Excavating**

11. BIRTHPLACE (State or foreign country):

**Maryland**12. CITIZEN OF WHAT  
COUNTRY?**USA**

## 13. FATHER'S NAME:

**Charles A. Rogers**

## 14. MOTHER'S MAIDEN NAME:

**Nora Hardey**15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of  
service)**Yes** **World War I**

## 16. SOCIAL SECURITY No.:

**213-24-9810**

## 17. INFORMANT &amp; ADDRESS:

**Mrs. James A. Rogers - Frederick, Maryland**

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

**157X**  
**Immediate cause**(a) **Carcinoma of pancreas**  
DUE TOAntecedent causes (s)  
Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last.

(b) DUE TO

(c)

Interval Between  
Onset And Death**8 mos.**

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

**27 Dec 1954**

## 19b. MAJOR FINDINGS OF OPERATION

**Carcinoma of pancreas**

## 20. AUTOPSY ?

Yes ☐ No ☒21. ACCIDENT  
SUICIDE  
HOMICIDE (Specify)PLACE (Home, farm, factory, street,  
OF office bldg., etc.)  
**INJURY**

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURYINJURY OCCURRED  
While at Not While  
Work ☐ At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from **6 Dec**, 1954, to **11 June**, 1955, that I last saw the deceasedalive on **11 June**, 1955, and that death occurred at **7:10 A.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION,  
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL  
REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

**13 June 1955** **Elizabeth B. Hesch****C. E. Cline & Son - 8 East Patrick Street****Frederick, Maryland**

MARGIN RESERVE FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUN 14 1955  
BUREAU V. S.

5599

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Frederick</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X <b>TOWN Rural - Nr. Frederick</b>		<b>Over 50 years</b>		X <b>TOWN Braddock Heights</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Vindobona Convalescent Home</b>				STREET ADDRESS (If rural give location) <b>Braddock Heights</b>			
3. NAME OF DECEASED: (First) <b>ALICE</b>		(Middle) <b>MECKEL</b>		(Last) <b>ROHRBACK</b>		4. DATE OF DEATH: <b>June 3 1955</b>	
5. SEX: <b>Female</b>		6. COLOR OR RACE: <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Widowed</b>		8. DATE OF BIRTH: <b>October 6, 1876</b>	
9. AGE last birthday: <b>78 yrs.</b>		10. DATE OF BIRTH: <b>October 6, 1876</b>		11. BIRTHPLACE (State or foreign country): <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY: <b>Own home</b>		11. BIRTHPLACE (State or foreign country): <b>Pennsylvania</b>	
13. FATHER'S NAME: <b>Gustavus Meckel</b>				14. MOTHER'S MAIDEN NAME: <b>Anna Worthington</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY No.: <b>None</b>		17. INFORMANT & ADDRESS: <b>Miss Anna Mary Rohrback - Braddock Heights, Md.</b>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
Immediate cause <b>443X Cerebral Hemorrhage</b>						<b>24 hr.</b>	
Antecedent causes (s) <b>260X Hypertensive Cardiovascular disease</b>						<b>10 yrs +</b>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.							
11. OTHER SIGNIFICANT CONDITIONS <b>Diabetes mellitus</b>						<b>10 yrs +</b>	
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <b>0</b>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? <b>Yes</b> <input type="checkbox"/> <b>No</b> <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Feb 21, 1955</b> , to <b>June 3, 1955</b> , that I last saw the deceased alive on <b>June 2, 1955</b> , and that death occurred at <b>6:30 A.M.</b> , from the causes and on the date stated above.							
SIGNATURE <b>Henry V. Chase M.D.</b>		(Degree or title)		ADDRESS <b>4 E Church St</b>		DATE SIGNED <b>6/4/55</b>	
23. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>June 6, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>4 June 1955</b>		REGISTRAR'S SIGNATURE <b>Elizabeth S. Hech</b>		24. FUNERAL DIRECTOR <b>C. E. Cline &amp; Son - 8 East Patrick Street</b>			
				ADDRESS <b>Frederick, Maryland</b>			

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2.

JUN 9 1955

RECEIVED



5576

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Frederick</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Frederick</b>		LENGTH OF STAY (in this place) <b>Life</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>151 West Patrick Street</b>				STREET ADDRESS (If rural give location) <b>151 West Patrick Street</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>CHARLES FRANCIS SEEGER</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>June 4, 19 55</b>			
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. <del>SINGLE, MARRIED, WIDOWED, DIVORCED.</del> (Specify): <b>Widower</b>	8. DATE OF BIRTH: <b>April 12, 1878</b>	9. AGE last birthday: <b>77</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Hardware Store</b>		11. BIRTHPLACE (State or foreign country): <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>Peter Seeger</b>				14. MOTHER'S MAIDEN NAME: <b>Maria Woerner</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT & ADDRESS: <b>151 West Patrick Street A. Melvin Seeger, Frederick, Maryland</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Cornary Thrombosis</b>						<b>5 minutes</b>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (B) <b>Arteriosclerotic Heart Disease</b>						<b>3 years</b>	
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <b>0</b>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Jan</b> , 1952, to <b>4 June</b> , 1955, that I last saw the deceased alive on <b>4 June</b> , 1955, and that death occurred at <b>4:55A M.</b> from the causes and on the date stated above.							
SIGNATURE <b>Thomson &amp; Stone</b>		M. D. <b>Frederick, Maryland</b>		DATE SIGNED <b>6/4/1955</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>June 6, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>6 June 1955</b>		REGISTRAR'S SIGNATURE <b>Elizabeth B. Hesch</b>		24. FUNERAL DIRECTOR <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		ADDRESS	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JUN 8 1975

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05605

5600

## CERTIFICATE OF DEATH

Reg. Dist. No. 144

1. PLACE OF DEATH: COUNTY <b>Frederick</b> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Rocky Ridge rural</b> LENGTH OF STAY (in this place) <b>50 yrs.</b>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <b>Md.</b> COUNTY <b>Frederick</b> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Rocky Ridge Rural</b> STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) <b>Edna</b> (Middle) <b>Bernice</b> (Last) <b>Shriner</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>June 23 19 55</b>			
5. SEX: <b>female</b>		6. COLOR OR RACE: <b>white</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>widowed</b>		8. DATE OF BIRTH: <b>July 26, 1890</b>	
9. AGE last birthday: <b>64</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if <b>Housewife</b> )		11. BIRTHPLACE (State or foreign country): <b>Frederick County</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>Joseph Miller</b>				14. MOTHER'S MAIDEN NAME: <b>Margaret Ecker</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <b>Carl Shriner Rocky Ridge, Md.</b>	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>331X</b> IMMEDIATE CAUSE (A) <b>Cerebral Hemorrhage</b> ANTECEDENT CAUSE (S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <b>(260X)</b> C) <b>Diabetes Mellitus</b>						INTERVAL BETWEEN ONSET AND DEATH <b>21 days</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<b>5 yrs.</b>	
19A. DATE OF OPERATION: <b>None</b>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>None</b> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>June 22, 1955</b> , to <b>June 23, 1955</b> , that I last saw the deceased alive on <b>June 22, 1955</b> , and that death occurred at <b>4:50 P.M.</b> , from the causes and on the date stated above. SIGNATURE <b>James K. Gray</b> M.D. ADDRESS <b>Thurmont Md.</b> DATE SIGNED <b>June 24-1955</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>June 26, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Mt. Tabor Cem.</b>		LOCATION (City, town, or county) (State) <b>Rocky Ridge Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>June 25, 1955</b>		REGISTRAR'S SIGNATURE <b>Blanchette S. Eyles</b>		24. FUNERAL DIRECTOR <b>M.L. Creager &amp; Son</b>		ADDRESS <b>Thurmont, Md.</b>	

BUREAU V. S.

JUN 28 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05606

5691

## CERTIFICATE OF DEATH

Reg. Dist. No. 144

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b> COUNTY <b>Frederick</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<b>Thurmont</b>		<b>79 yrs.</b>		<b>Thurmont</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>00</b>				<b>1</b>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)					
<b>Annie K. Smith</b>		<b>June 28 1955</b>					
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
<b>Female</b>	<b>White</b>	<b>Widow</b>	<b>6/12/76</b>	<b>79 yrs.</b>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
<b>Housewife—Own home</b>			<b>None</b>		<b>Thurmont, Md. Rural</b>		<b>Citizen 88A</b>
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<b>Upton Geisbert</b>				<b>Mary Susan Hoffman Geisbert</b>			
15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<b>No</b>		<b>None</b>		<b>Mrs. Morris Stambaugh Thurmont, Md.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>420.1 Coronary occlusion</b>						<b>21 hr.</b>	
ANTECEDENT CAUSE (B) <b>Arteriosclerosis</b>						<b>?</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) <b>Hypertension</b>						<b>3 yrs.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>0</b>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>June 27, 1955</b> , to <b>June 28, 1955</b> , that I last saw the deceased alive on <b>June 27, 1955</b> , and that death occurred at <b>3:00 AM</b> , from the causes and on the date stated above.							
SIGNATURE <b>M. Frank Davis</b>		M. D. <b>Thurmont, Md.</b>		DATE SIGNED <b>6/28/55</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>6/30/55</b>		<b>United Brethern Cem.</b>		<b>Thurmont, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<b>June 29, 1955</b>		<b>Blanche S. Eyles</b>		<b>M.L. Creager and Son</b>		<b>Thurmont, Md.</b>	

BUREAU V. S.

JUL 1 1955

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 147

1. PLACE OF DEATH COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town.) TOWN <u>Mt. Airy</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Mt. Airy</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural, give location) <u>Hill Street</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>INDIA</u> <u>SMITH</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE</u> <u>5</u> , 19 <u>55</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>4-25-1863</u>
9. AGE last birthday <u>92</u> yrs.		10. AGE last birthday If under 1 year If under 24 hrs. <u>92</u> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Samuel Lowe</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Clary</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT <u>Mrs. Della Becraft, Mt. Airy, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Cerebral hemorrhage</u>		<u>3 dys</u>	
Antecedent cause(s) (b) <u>Infirmities of age (91 yrs)</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 5</u> , 19 <u>55</u> , to <u>Jan 5</u> , 19 <u>55</u> that I last saw the deceased alive on <u>June 4</u> , 19 <u>55</u> and that death occurred at <u>2 a</u> m., from the causes and on the date stated above.			
SIGNATURE (Degree or title) <u>C. M. Waltz M.D.</u>		ADDRESS <u>Mt. Airy Md</u>	
DATE SIGNED <u>6/5/55</u>			
23. BURIAL, CREMATION REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>June 7, 1955</u>		<u>Prospect Frederick Co., Md.</u>	
24. FUNERAL DIRECTOR <u>C. M. Waltz, Winfield, Md.</u>			

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING



BUREAU V. S.

JUN 9 1955

RECEIVED

5577

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Frederick</u> MARYLAND			STATE <u>Maryland</u> COUNTY <u>Frederick</u>		
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Frederick</u>			CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Frederick Memorial Hospital</u>			STREET ADDRESS (If rural give location) <u>74 Carver Apt, Broadway and Madison St</u>		
3. NAME OF DECEASED: (Type or Print) <u>Arthur</u> (First) <u>Henry</u> (Middle) <u>Snowden</u> (Last)			4. DATE OF DEATH: <u>June</u> (Month) <u>29</u> (Day) <u>1955</u> (Year)		
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Negro</u>	7. <del>SINGLE, MARRIED, WIDOWED, DIVORCED,</del> (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Feb 16, 1934</u>		9. AGE last birthday: <u>21</u> yrs. <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired <u>Contractors Helper</u>			10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Frederick, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			13. FATHER'S NAME: <u>Arthur Snowden, Sr</u>		
14. MOTHER'S MAIDEN NAME: <u>Geneva Bowie</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		
16. SOCIAL SECURITY No.: <u>217-28-5890</u>			17. INFORMANT & ADDRESS: <u>Betty P. Snowden 74 Carver Apts</u>		

18. MEDICAL CERTIFICATION				Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
<u>401.0</u> Immediate cause (a) <u>Pericarditis, acute &amp; effusion</u>				<u>4 weeks</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>acute Rheumatic Fever</u>				<u>4 weeks</u>	
(c) <u>Rheumatic heart disease, chronic</u>				<u>years</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY ? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR ?	
22. I hereby certify that I attended the deceased from <u>Jan 14, 1955</u> , to <u>June 29, 1955</u> , that I last saw the deceased alive on <u>June 22, 1955</u> , and that death occurred at <u>6:45 A.M.</u> , from the causes and on the date stated above.					
SIGNATURE <u>Robert S. Turner, Jr.</u>		(Degree or title) <u>M.D.</u>		ADDRESS <u>7 E. Church St. Frederick Md</u>	
DATE SIGNED <u>July 1955</u>		DATE THESE OF <u>July 2</u>		NAME OF CEMETERY OR CREMATORY <u>Fairview</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		LOCATION (City, town, or county) <u>Frederick Maryland</u>		(State) <u>Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>July 1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth S. Heck</u>		24. FUNERAL DIRECTOR <u>Charles E. Hicks, 111 24 West All Saints St</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 6 1955

RECEIVED

5578

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Frederick		MARYLAND		STATE Maryland		COUNTY Frederick	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
11 <del>TOWN</del> Frederick		Life		11 <del>TOWN</del> Frederick			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
69 Frederick Memorial Hospital				504 Lee Place			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year) OF DEATH:			
(First) LUTHER		(Middle) CHARLES		(Last) STITLEY		June 24, 1955	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Female		White		Single		9 June 1955	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday	
Infant						yrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY?			
Maryland				USA			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Charles Stitley				Mary Frances Buchanan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
15 No				None		504 Lee Place, Charles Stitley, Frederick, Maryland	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
762.0 IMMEDIATE CAUSE						(A) <i>Acute spontaneous pneumothorax, l. 18 hrs.</i>	
ANTECEDENT CAUSE (S)						DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						(B) DUE TO	
						(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
2							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
M.							
22. I hereby certify that I attended the deceased from 23 June 1955, to 24 June 1955, that I last saw the deceased alive on 24 June 1955, and that death occurred at 8 A. M, from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
A. M. Powell, Jr.				M. D. Frederick, Maryland		24 June 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		25 June 1955		Lutheran Cemetery		Jefferson, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
24 June 1955		Elizabeth S. Heck		M. R. Etchison & Son, Frederick, Maryland			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 27 1965

RECEIVED

1 5603

## CERTIFICATE OF DEATH

Reg. Dist. No. 145

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Frederick</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Frederick</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Rural- Myersville</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Myersville</u>			
TOWN <u>Myersville</u> 96 yrs.				TOWN <u>Myersville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>Route # 1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>MARY ELLEN STOTTEMYER</u>				<u>June 13 1955</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
<u>Female</u>		<u>White</u>		<u>Widowed</u>		<u>Feb. 18, 1859</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>		11. BIRTHPLACE (State or foreign country): <u>Nr. Myersville, Fred. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Levin Hurley</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Munson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>#no</u>		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>G. Marvin Stottlemeyer, Myersville, Md.</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
<u>450.0</u> Immediate cause (a) <u>Generalized Arterio Sclerosis</u>							
Antecedent causes (s) (b) <u>DUE TO</u>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>DUE TO</u>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>0</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 12, 1955</u> , to <u>June 13, 1955</u> , that I last saw the deceased alive on <u>June 8, 1955</u> , and that death occurred at <u>7:15 P</u> from the causes and on the date stated above.							
SIGNATURE <u>J. E. Harp Md</u>				ADDRESS <u>Woodstown</u> DATE SIGNED <u>6-14-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 16, 1955</u>		<u>United Brethren</u>		<u>Wolfsville, Fred. Co. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>June 16, 1955</u>		<u>Floy M. Bittle</u>		<u>Paul F. Bittle, Myersville, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 20 1955

BUREAU V. S.



5580

## CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Frederick</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>		LENGTH OF STAY (in this place) <b>2 days</b>		OR TOWN <b>Burkittsville</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Frederick Memorial Hospital</b>				STREET ADDRESS (If rural give location) <b>/</b>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year) OF DEATH:			
(First) <b>DENNIS</b>		(Middle) <b>JAMES</b>		(Last) <b>SULCER</b>		<b>June 29, 1955</b>	
(Type or Print)							
5. SEX: <b>Male</b>		6. COLOR OR RACE: <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Single</b>		8. DATE OF BIRTH: <b>27 June 1955</b>	
						9. AGE last birthday: <b>2</b> yrs. <b>2</b> Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Infant</b>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <b>Maryland</b>	
						12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>Maynard Vernon Sulcer</b>				14. MOTHER'S MAIDEN NAME: <b>Helen Louise Smith</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.): <b>No</b> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.: <b>None</b>		17. INFORMANT & ADDRESS: <b>Burkittsville, Mrs. Maynard V. Sulcer, Maryland</b>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<b>2 days</b>	
IMMEDIATE CAUSE (A) <b>atelectasis</b>							
ANTECEDENT CAUSE (B) <b>Complic. left lung &amp; 1/2 rt lung</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <b>1/2 rt lung</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <b>0</b>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>June 27, 1955</b> to <b>June 29, 1955</b> ; that I last saw the deceased alive on <b>June 29, 1955</b> , and that death occurred at <b>7:25 A.M.</b> , from the causes and on the date stated above.							
SIGNATURE <b>Bl... ..</b>				ADDRESS <b>Frederick, Md 6/29/55</b>			
M. D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>6/29/55</b>		NAME OF CEMETERY OR CREMATORY <b>Utica Cemetery</b>		LOCATION (City, town, or county) (State) <b>Frederick County Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>29 June 1955</b>		REGISTRAR'S SIGNATURE <b>Elizabeth S. Heck</b>		24. FUNERAL DIRECTOR <b>M. R. Etchison &amp; Son, Frederick, Md.</b>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 1 1955

RECEIVED

5579

## MARYLAND STATE DEPARTMENT OF HEALTH

05612

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 131

1. PLACE OF DEATH- COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Frederick	
CITY (If outside corporate limits, write RURAL and give nearest town) Frederick		CITY (If outside corporate limits, write RURAL and give nearest town) Frederick	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 800 Montclair Avenue		STREET ADDRESS (If rural, give location) 800 Montclair Avenue	
3. NAME OF DECEASED (First) ELISABETH (Middle) MARTIN (Last) SULLIVAN	4. DATE OF DEATH (Month) June 5, (Day) 5, (Year) 1955		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW	8. DATE OF BIRTH 4 Oct 1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Feature-Writer		10b. KIND OF BUSINESS OR INDUSTRY Newspaper	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Joseph Snyder	
14. MOTHER'S MAIDEN NAME Mary Martin Willson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY No. 578-10-1637		17. INFORMANT AND ADDRESS 3605 21st Ave., Mr. Thomas W. Sullivan, North Arlington, Va.	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

976x Immediate cause (a) GUNSHOT WOUND OF HEAD

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 21 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING ☐ PLACE (Home, farm, factory, street, office bldg., etc.) Home (CITY OR TOWN) Frederick-Frederick, (COUNTY) Maryland

TIME (Month) (Day) (Year) (Hour) OF INJURY CA June 5, 1955? m. INJURY OCCURRED While at work ☐ Not while at work ☒ HOW DID INJURY OCCUR? Shot Self With Pistol

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☒ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Robert J. June, M. D. Deputy Medical Examiner, Frederick, Md. 9 June 1955

23. BURIAL INFORMATION DATE THEREOF 13 June 1955 NAME OF CEMETERY OR CREMATORY Arlington National Cemetery LOCATION (City, town, or county) Arlington, Virginia (State)

DATE REC'D BY LOCAL REG. 10 June 1955 REGISTRAR'S SIGNATURE Elizabeth L. Heck 24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

BUREAU V. S.

JUN 13 1955

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5604

## CERTIFICATE OF DEATH

Reg. Dist. No. 056134

## 1. PLACE OF DEATH:

COUNTY Frederick

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Emmitsburg,

LENGTH OF STAY  
(in this place)  
2 yrs.HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland

COUNTY Frederick

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Emmitsburg,

STREET ADDRESS  
(If rural give location)3. NAME OF  
DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

Emily

Virginia

Tokar

4. DATE  
OF  
DEATH:

(Month)

(Day)

(Year)

JUNE

25

1955

## 5. SEX:

6. COLOR OR  
RACE:7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify):

## 8. DATE OF BIRTH:

## 9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.

Female

White

Married

Aug. 20, 1909

45

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION. Give kind of  
work done during most of working life,  
even if retired): Nurse10b. KIND OF BUSINESS OR  
INDUSTRY:  
Registered Nurse11. BIRTHPLACE (State or foreign country):  
Emmitsburg, Frederick Co. U.S.A.

## 13. FATHER'S NAME:

Albert Adelsberger

## 14. MOTHER'S MAIDEN NAME:

Carrie Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.)

Yes

(If Yes give war or date of  
service)Nov. 25, 1943  
Oct. 7, 1946

## 16. SOCIAL SECURITY No.:

None

## 17. INFORMANT &amp; ADDRESS:

Ervin C. Tokar

Emmitsburg, Md.

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

353.3

Immediate cause

(a)

Acute Cardiac Dilatation with failure

Interval Between  
Onset And Death

1/2 hr.

Antecedent causes(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last.

(b)

Epilepsy

several  
years

(c)

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

Acute and Chronic alcoholism

years

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY ?

Yes ☐ No ☐21. ACCIDENT  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,  
OF  
office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF  
INJURYINJURY OCCURRED  
White at Not While  
Work ☐ At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from ..... 19....., to ..... 19....., that I last saw the deceased

alive on ..... 19....., and that death occurred at 4:30 A.M. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Charles R. Williams

M.D.

Emmitsburg Md

June 25, 1955

23. BURIAL, CREMATION,  
REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

Burial

June 28, 1955

Mt. View

Emmitsburg, Frederick Co. Md.

DATE REC'D BY LOCAL  
REGISTRAR

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

June 27 - 1955 M. F. Shuff

S. L. Allison

Emmitsburg, Md.

S. L. Allison

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 1 1955

RECEIVED

05614

## MARYLAND STATE DEPARTMENT OF HEALTH

5695

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 134

1. PLACE OF DEATH - COUNTY <b>Frederick</b>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <b>Maryland</b>		COUNTY <b>Frederick</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>Rural Emmitsburg</b>		LENGTH OF STAY (in this place) <b>14 yrs.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Rural Emmitsburg, Md.</b>		<b>X</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Emmitsburg, MD. # 1</b>				STREET ADDRESS (If rural, give location) <b>Emmitsburg, R.D. # 1</b>		<b>1</b>	
3. NAME OF DECEASED (First) (Middle) (Last) <b>MAGGIE CORNELIA TRENT</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>JUNE 18 1953</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>		8. DATE OF BIRTH <b>Jan. 9, 1905</b>	
				9. AGE last birthday <b>50</b> yrs.		10. If under 1 year Months Days Hours Min. <b>18</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Lee County Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Archie J. King</b>		14. MOTHER'S MAIDEN NAME <b>Sara Battley</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-14-1722</b>	
				17. INFORMANT AND ADDRESS <b>Mrs. S. L. Allison</b>		<b>Emmitsburg Md. R.D. 1</b>	

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
433.1 Immediate cause (a) <b>Heart disease - probably acute pulmonary edema following paroxysmal</b>		
Antecedent cause(s) (b) <b>tachycardiac fibrillation</b>		
322.0 (c) <b>Acute alcoholism</b>		<b>6 hrs</b>

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE <b>Charles H. Corley, M.D.</b>		(Degree or title) <b>med Exm Frederick Md.</b>		DATE SIGNED <b>6/18/53</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>June 21, 1953</b>	NAME OF CEMETERY OR CREMATORY <b>Mt. View</b>	LOCATION (City, town, or county) <b>Emmitsburg, Md.</b>	(State)	
DATE REC'D BY LOCAL REG. <b>June 19 1953</b>		REGISTRAR'S SIGNATURE <b>M. F. Shuff</b>		24. FUNERAL DIRECTOR <b>S. L. Allison</b>	
				ADDRESS <b>Emmitsburg, Md.</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

JUN 22 1955

BUREAU V. S.

5676

## CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR		TOWN	
TOWN <b>Cullen</b>		<b>445 days</b>		TOWN <b>Baltimore</b>		<b>3401.4</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Victor Cullen State Hosp.</b>				STREET ADDRESS (If rural give location) <b>4227 Ivanhoe Ave.</b>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<b>Frank Ralph Williams</b>				<b>6 14 1955</b>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<b>M</b>		<b>W</b>		<b>Married</b>		<b>1/9/1891</b>	
9. AGE last birthday		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
<b>64 yrs.</b>							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Barber</b>				10B. KIND OF BUSINESS OR INDUSTRY: <b>Barber</b>		11. BIRTHPLACE (State or foreign country): <b>Pennsylvania.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME: <b>Louis Williams</b>				14. MOTHER'S MAIDEN NAME: <b>Mary Shavaise</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) (If Yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY No. <b>212-20-8296</b>		17. INFORMANT & ADDRESS: <b>Frank R. Williams, 4227 Ivanhoe Ave., Balto., Md.</b>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Pulmonary tuberculosis</b>							<b>18 mos.</b>
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <b>0</b>		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>3/26, 1954</b> , to <b>6/14, 1955</b> that I last saw the deceased alive on <b>6/14, 1955</b> , and that death occurred at <b>6:30 A.M.</b> , from the causes and on the date stated above.							
SIGNATURE <b>[Signature]</b>		ADDRESS <b>Cullen, Maryland.</b>		DATE SIGNED <b>6/14/55</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>6-16-55</b>		NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Park</b>		LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>6/14/55</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		24. FUNERAL DIRECTOR <b>J.B. Lyon, M.D.</b>		ADDRESS <b>John A. Moran, 3000 E. Balto. St.</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 16 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5697

## CERTIFICATE OF DEATH

Reg. Dist. No.

05616

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Frederick</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Frederick</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<b>Thurmont</b>		<b>43 yrs.</b>		<b>Thurmont</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>00</b>				<b>W. Main St.</b>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
<b>LILLIE X CATHERINE WOOLARD</b>				<b>June 5 1955</b>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
<b>Female</b>		<b>White</b>		<b>Widowed</b>		<b>June 13, 1883</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday		IF UNDER 1 YEAR IF UNDER 24 HRS.	
<b>Housewife</b>		<b>Own Home</b>		<b>71</b> yrs.		<b>Months Days Hours Min.</b>	
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY?			
<b>Thurmont, Fred. Co. Md.</b>				<b>U.S.A.</b>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<b>Emanuel Carbaugh</b>				<b>Mary Ellen O'Connor</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<b>3 no</b>				<b>218-07-1430</b>			
17. INFORMANT & ADDRESS:							
<b>Ernest Woolard, Thurmont, Md.</b>							
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Heart Failure, Coronary occlusion</b>							
ANTECEDENT CAUSE (B) <b>Cardiac asthma</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<b>None</b>							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
<b>None</b>							
22. I hereby certify that I attended the deceased from <b>June 1, 1953</b> to <b>June 5, 1955</b> , that I last saw the deceased alive on <b>May 11, 1955</b> , and that death occurred at <b>4 A.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>James K. Gray</b>				DATE SIGNED <b>June 6-1955</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				24. FUNERAL DIRECTOR ADDRESS			
<b>Burial</b>				<b>M.L. Creager &amp; Son, Thurmont, Md.</b>			
DATE REC'D BY LOCAL REGISTRAR <b>June 7 1955</b>				REGISTRAR'S SIGNATURE <b>Blanche S. Eyles</b>			

BUREAU V. S.

JUN 9 1955

RECEIVED

05617

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

5698

## CERTIFICATE OF DEATH

Reg. Dist. No. 147

1. PLACE OF DEATH- COUNTY <b>Frederick</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Frederick</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>X TOWN rural--Mt. Airy</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>TOWN rural--Mt. Airy</b> <b>X</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00</b>		STREET ADDRESS (If rural, give location) <b>Woodville</b>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <b>EMMA. L. YOUNG</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>June 21 1955</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>6-21-1883</b>
9. AGE last birthday <b>72</b> yrs.		10. If under 1 year Months Days Hours Mln.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Ann Anderson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT AND ADDRESS <b>Mrs. Jeanette Leaf, Mt. Airy, Md.</b>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
331X Immediate cause (a) <b>Cerebral Hemorrhage</b>		6/20	
Antecedent cause(s) (b) <b>Hypertension</b>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Jan</b> , 19 <b>55</b> , to <b>June 21</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>June 20</b> , 19 <b>55</b> , and that death occurred at <b>3:50</b> p.m., from the causes and on the date stated above.			
SIGNATURE <b>C. M. Waltz</b>		ADDRESS <b>Winfield, Md.</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>		DATE THEREOF <b>6-24-1955</b>	
NAME OF CEMETERY OR CREMATORY <b>Locust Grove Brethren, Frederick Co., Md.</b>		LOCATION (City, town, or county) (State) <b>Frederick Co., Md.</b>	
DATE REC'D BY LOCAL REG. <b>June 23, 1955</b>		24. FUNERAL DIRECTOR ADDRESS <b>C. M. Waltz, Winfield, Maryland</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU V. S.

JUN 27 1955

RECEIVED



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5699

## CERTIFICATE OF DEATH

Reg. Dist. No. 056181

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Frederick</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Frederick</i>
<del>CITY</del> (If outside corporate limits, write RURAL and give nearest town) <i>X</i> OR TOWN <i>Rural Middletown</i>	LENGTH OF STAY (in this place)	<del>CITY</del> (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Rural Middletown</i> <i>X</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>10</i>		STREET ADDRESS (If rural give location) <i>1</i>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) <i>Charles</i>	(Middle) <i>Elmer</i>	(Last) <i>Younkins</i>	<i>6 15 19 55</i>
5. SEX: <i>male</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>married</i>	8. DATE OF BIRTH: <i>1-25-1900</i>
9. AGE last birthday: <i>55</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Flagman U.S.</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>railroad</i>	
11. BIRTHPLACE (State or foreign country): <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME: <i>Charles Younkine</i>		14. MOTHER'S MAIDEN NAME: <i>Lula Moore</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <i>No</i>		16. SOCIAL SECURITY No.	
17. INFORMANT & ADDRESS: <i>Charles E. Younkine, Middletown, Md.</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Cerebral Hemorrhage</i>			<i>9 hrs</i>
ANTECEDENT CAUSE (S) DUE TO (B) <i>Hypertension</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>June 15, 1955</i> , to <i>June 15, 1955</i> , that I last saw the deceased alive on <i>June 15, 1955</i> , and that death occurred at <i>9:15 A.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>J E Harp Md</i>		ADDRESS <i>Middletown</i> M.D. <i>6-16-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>6-18-1955</i>	
NAME OF CEMETERY OR CREMATORY <i>Ch. of God Cemetery</i>		LOCATION (City, town, or county) (State) <i>Loose Valley (Middletown) Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>18 June 1955</i>		REGISTRAR'S SIGNATURE <i>Elizabeth G. Healy</i>	
24. FUNERAL DIRECTOR <i>Gladihill Co.</i>		ADDRESS <i>Middletown, Md.</i>	

BUREAU V. S.

JUN 22 1955

RECEIVED